

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this form has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 3 2 4 6 1			
1- STATE REGISTRAR					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Mary E Abney</u>					2a. DATE OF DEATH MONTH DAY YEAR 12 29 82			
3. SEX <u>Female</u>					2b. HOUR 11 ⁰³ _M			
4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR 8 23 13		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Whitmore, S. C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONT</u> MD.		
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>D. C.</u> 13b. CITY OR TOWN <u>Washington</u>					13c. STREET ADDRESS <u>611 Edgewood St. N.E.</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Mitchell Fant</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Unknown</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>					16b. SOCIAL SECURITY NO. <u>249-36-1362-A</u>			
17. INFORMANT <u>Mr. Stewart C. Rice/son/9200 Edwards Way</u>					ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>1749</u> IMMEDIATE CAUSE (a) <u>Maternal great Circulation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Delayed Circulation Placental separation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fibrous adhesive and carcinomatous peritoneal tags</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>days</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Aspiration Gastric content. Advanced Hypertension</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 26</u> , 19 <u>82</u> , to <u>Dec 29</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Dec 28</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Hugo G. Graniani</u> 50						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-30-82</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Hugo G. Graniani</u>			22e. ADDRESS <u>717 Parkway Dr. S.S. Md. 20910</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>1-4-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR NAME <u>John T. Rhines Co., 3015 12th St. N.E. D.C. 20017</u>			ADDRESS		25a. DATE REC'D. BY REGISTRAR <u>JAN 4 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John T. Rhines</u>	

BP

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 4 6 2														
1. FOR STATE REGISTRAR			REG. NO.																					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		M					
Constance M. Adams									12		1		82		10 PM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 74 MRS.									
F			W			2-2-09			73			YRS			MONTHS			DAYS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH															
WASH., D.C.			U.S.A.						Montgomery MD															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION										12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR								
TAKOMA PK.			WASHINGTON ADVENTIST HOSP.										FED. GOVERNMENT			N.T.H.								
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS								
M.D.										Montgomery		Wheaton		YES <input type="checkbox"/> NO <input type="checkbox"/>		11111 Anshest Ave								
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME														
ALFONSO										ELIZABETH DIEHL														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/> IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO.		17. INFORMANT												
NO										577-01-1762		WARREN P. ADAMS HUSBAND 11111 ANSHEST AVE. WHEATON, MD												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART 1: DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
1749 IMMEDIATE CAUSE (a) <u>myocardial infarction</u>																								
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.										(b) _____														
(c) _____																								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
					HOUR A.M. MONTH DAY YEAR																			
					P.M. 19																			
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION														
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ALONE <input type="checkbox"/>										CITY OR TOWN COUNTY STATE														
22a. I certify that (in this hospital) attended the deceased from 12/9/82, to 12/1/82, that (I) (we) lost <u>now the deceased alive on 12/1/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated																								
22b. SIGNATURE															DEGREE					22c. DATE SIGNED				
<u>Lewis H. Dennis</u>																				12/1/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)															22e. ADDRESS									
LEWIS H. DENNIS															831 UNIVERSITY BLVD. EAST, SILVER SPRING, MD									
23a. BURIAL, CREMATION, REMOVAL					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION									
CREMATION					DEC. 3, 1982					METROPOLITAN CREM.					ALEXANDRIA COUNTY VIRGINIA									
24. FRANKIE J. COLLINS 500 UNIVERSITY BLVD. WEST FUNERAL HOME SILVER SPRING, MD.															25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
															DEC 8 - 1982					<u>John J. Connel</u>				

FRANCIS J. COLLINS 500 UNIVERSITY BLVD. WEST
SILVER SPRING, MD.
ALEXANDRIA
VIRGINIA
LEWIS H. DENNIS
881 UNIVERSITY BLVD. EAST, SILVER SPRING, MD.

ALFONSO
777-71-1762 577-01-1762
WARRICK P. ADAMS
ELIZABETH
STEVE
777-71-1762 577-01-1762
WARRICK P. ADAMS
ELIZABETH
STEVE
777-71-1762 577-01-1762
WARRICK P. ADAMS
ELIZABETH
STEVE

WASHINGTON
FED. GOVERNMENT

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 4 6 3

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRY DeCoursey ADAMS			2a. DATE OF DEATH MONTH DAY YEAR 12 28 82			2b. HOUR 2050 M				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 16, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.				
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Doctor Dentist		12b. KIND OF BUSINESS OR INDUSTRY Dentistry		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Adams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Ann DeCoursey			13e. STREET ADDRESS (20877) 401 Russell Avenue				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 579 52 4113		17. INFORMANT Zellah B. Adams				ADDRESS 401 Russell Avenue Gaithersburg, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF and (c) Cerebrovascular Accident APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 4 years 12/19/82										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1974 , to Dec 28 , 19 82 , that (I) (we) lost saw the deceased alive on Dec 28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE G. Stuart Scott			DEGREE			22c. DATE SIGNED Dec 29, 1982				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Stuart Scott, M.D.			22e. ADDRESS 6320 Democracy Blvd. Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Md. Gaithersburg			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND					25a. DATE RECEIVED BY REGISTRAR 1 JAN 5 1983					

BP

(4)

Dear Sir,
I have the pleasure to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. H. Smith

Yours truly,
J. H. Smith

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5. FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 4 6 4	
1. DECEASED NAME (TYPE OR PRINT) <i>Nellie W. Adams</i>						2a. DATE KNOWN OF DEATH ESTIMATED <i>Dec 16, 1982</i>		2b. HOUR <i>8:20 AM</i>		2c. DATE PRONOUNCED DEAD <i>Dec 16, 1982</i>	
1. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 28, 1924</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>58</i>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2d. DATE PRONOUNCED DEAD <i>Dec 16, 1982</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery, MD.</i>	
10. CITY OR TOWN OF DEATH <i>Mt. Spg.</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hosp</i>				12a. USUAL OCCUPATION (TYPE OF FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>						13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Beltsville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Henry White</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Catherine Elizabeth Davis</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>						16b. SOCIAL SECURITY NO. <i>220-44-0024</i>		17. INFORMANT ADDRESS <i>6605 Spring Valley Dr., Alex. Ellis C. Adams, Son Va. 22312</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>3880 PNEUMONIA BILATERAL</i> IMMEDIATE CAUSE (a) <i>Pneumoniz Bilateral</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Fracture L. Tibia and Fibula</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Fracture L. Tibia and Fibula</i>											
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>—</i>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 12:4 1982</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Not known</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <i>AT WORK</i>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Nursing Home</i>		21f. LOCATION (CITY OR TOWN, STREET, COUNTY, STATE) <i>Queens Chapel Rd Hyattsville Prince Md</i>					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. DATE <i>Dec 16, 1982</i>	
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <i>M.D. B.C.P.</i>				DATE SIGNED <i>Dec 16, 1982</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i>				ADDRESS <i>1919 Seminary Rd., Silver Sp,</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>12-20-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl. Cem.</i>				23d. LOCATION (CITY OR TOWN, COUNTY, STATE) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR NAME <i>Robt E Wilhelm</i>				4308 Suitland Rd., Suitland, Md.				25. DATE REC'D. BY REGISTRAR <i>DEC 27 1982</i>			
Funeral Home								25. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			



X

X

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is to be notified and a post-mortem examination is required.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 3 2 4 6 5 REG. NO.					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward Vernon Ahlquist					MONTH DAY YEAR December 16, 1982					
3. SEX Male					2b. HOUR 10:55 PM					
4. RACE White					6. AGE (IN YEARS LAST BIRTHDAY) 69					
5. DATE OF BIRTH MONTH DAY YEAR Feb. 14 1913					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
7b. CITIZEN OF WHAT COUNTRY? USA					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Takoma Park					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired					12b. KIND OF BUSINESS OR INDUSTRY --					
13a. STATE Maryland					13b. CITY OR TOWN Pr. Georges Adelphi					
14. FATHER'S NAME FIRST MIDDLE LAST John Ahlquist					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Isaacson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 477-03-3037					
17. INFORMANT ADDRESS Tyney E. Ahlquist-wife- (same as 13e)										
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Lung Cancer to Liver								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 3 years 1 year		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from 18 Oct 82 to 16 Dec 82 , that (2) (we) last saw the deceased alive on 16 Dec 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (Type) (did) (did not) view the body after death.										
22b. SIGNATURE Thomas A. Bensinger						DEGREE MD		22c. DATE SIGNED 12/17/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger MD						22e. ADDRESS 7676 New Hampshire Ave Langley Pk MD 20783				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-20-1982			23c. NAME OF CEMETERY OR CREMATORY George Washington			23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Pr. Georges Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home						11800 N.H. Ave. ADDRESS S.S. Md. 20904		25a. DATE REC'D. BY REGISTRAR DEC 21 1982		
25b. REGISTRAR'S SIGNATURE [Signature]										

Items #10a-22a Film G575 1/26/83 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>		MONTH		DAY		YEAR		2b. HOUR			
Cynthia		S.		Alexander				12		21		19		82				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED		MONTH		DAY		YEAR		2d. HOUR	
Female		Caucasian		4 13 1968		14 YRS.						12		21		19		82		3:51 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH														AM	
Maryland		U.A.S.				Montgomery County														MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Silver Springs		Holy Cross Hospital		NONE																	
13a. STATE		13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1620 Moffett Rd.												20903	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
Robert		G. Alexander		Joan		C. Alex Thayer															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
NO		218-90-7993		Robert G. Alexander		Same 13e (Father)															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Chronic Interstitial Pneumonitis															
4960		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		Chronic Obstructive Pulmonary Disease															
				(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Mental Retardation																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																			
20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. TIME OF INJURY		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
		HOUR A.M. MONTH DAY YEAR																			
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21c. LOCATION																	
22a. I certify that I took charge of the remains described above, held on death resulted from:		Not from causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED																	
Hormez R. Guard, M.D.		M.D. Assistant		12/21/82																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																			
		111 Penn Street, Balto., MD 21201																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION															
Burial		Dec. 23, 1982		Parklawn Cemetery		Rockville															
24. FUNERAL DIRECTOR NAME		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE																	
FRANCIS J. COLLINS		DEC 27 1982		John J. Conish																	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Initial

Page 22 of 100

Female Caucasian 12 1900 14

U.S.A.

Robert O. Alexander

1910-1911

1912-1913

1914-1915

1916-1917

1918-1919

1920-1921

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2100-2101

2102-2103

2104-2105

2106-2107

2108-2109

2110-2111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 4 6 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST ELMER MIDDLE E. LAST ALLION			2a. DATE OF DEATH MONTH 12 DAY 13 YEAR 82		2b. HOUR 6:50 A. M.						
3 SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH Aug. DAY 1 YEAR 1895		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7c. IF UNDER 1 YEAR MONTHS 0 DAYS 0		7d. IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN P.G.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 8-C Hillside Rd. 20740					
14 FATHER'S NAME FIRST Franklin MIDDLE P. LAST Allion				15. MOTHER'S MAIDEN NAME FIRST Rebecca MIDDLE Schamps LAST Schamps							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YEAR OF BIRTH OR DATES) WW-1		17 INFORMANT Dennis W. Wagner		17 ADDRESS 9208 51st Ave. College Park, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Heart failure - arteriosclerosis - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis - longstanding years DUE TO, OR AS A CONSEQUENCE OF (c) decompensated - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12.3 , 19 82 , to 12.13 , 19 82 , that (I) (last) saw the deceased alive on 12.12 , 19 82 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.											
22b. SIGNATURE Frederic W. Brennwald				DEGREE Attending Physician				22c. DATE SIGNED 12.13.82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic W. Brennwald				22e. ADDRESS 831 University Blvd E. Silver Spring							
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 12-14-82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION Brentwood, P.G. Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons, P.A. 4739 Balt. Ave. Hyattsville, Md.						25a. DATE REC'D. BY REGISTRAR DEC 16 1982					
25b. REGISTRAR'S SIGNATURE John J. Connel											

Government of Tennessee
Department of Transportation
Bureau of Highway Construction
Nashville, Tennessee 37203

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

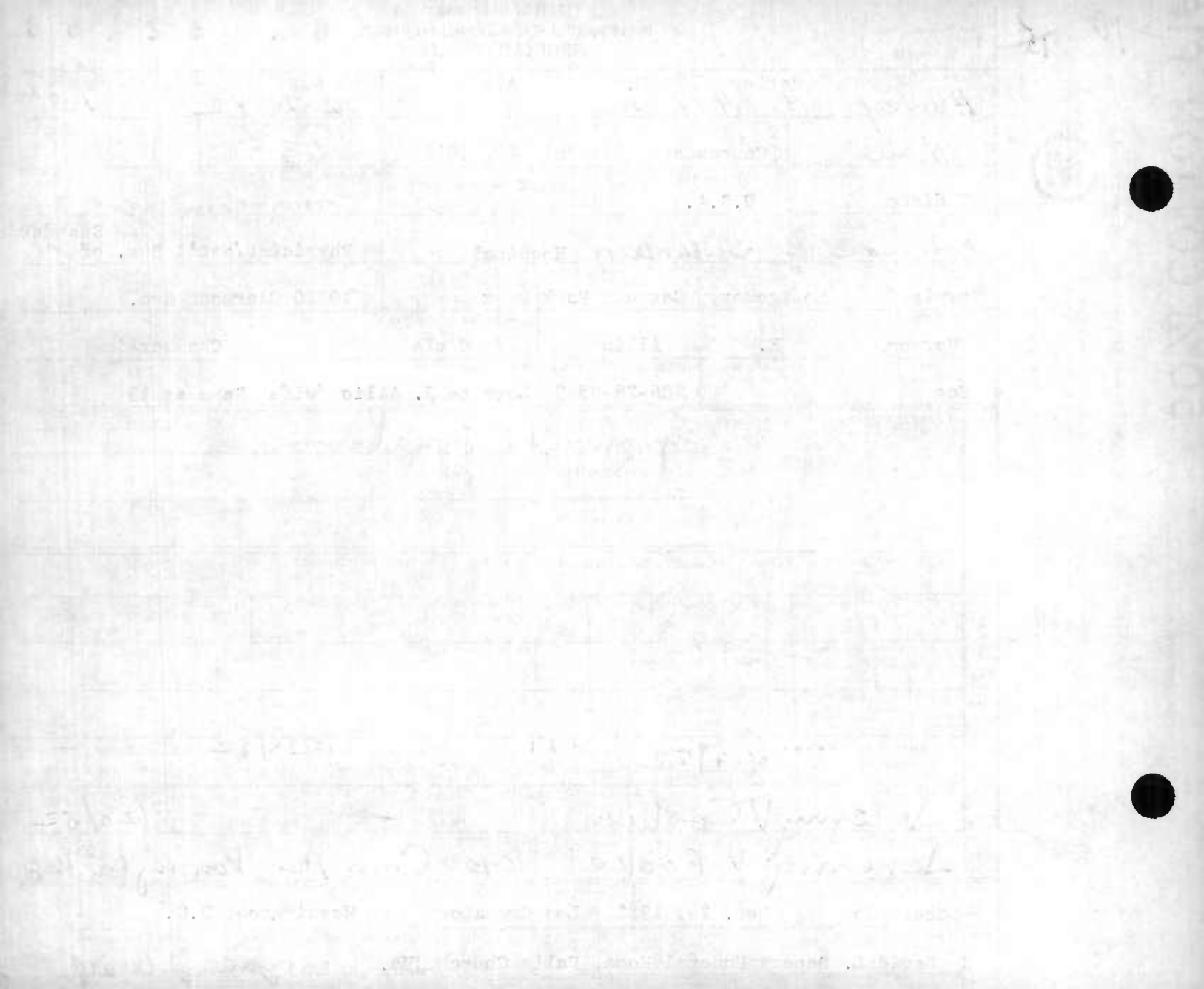
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 3 2 4 6 8			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) Harley H. Allion				2b. HOUR 1:10 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 27, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physicist/Nat'l		12b. INDUSTRY OR BUSINESS Standards Bur. of	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Garrett Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Vernon E. Allion		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clela Chamberlin		13e. STREET ADDRESS 10810 Clermont Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 286-26-3543		17. INFORMANT ADDRESS Loretta J. Allion/wife Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: 2049 Symphoctic Lymphoma							
DUE TO, OR AS A CONSEQUENCE OF (b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 1971 , 19____, to 12/28/82 , 19____, that (I) (we) last saw the deceased alive on 12/27/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jeremy V. Cooke		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cooke		22e. ADDRESS 10400 Conn. Ave. Kensington Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 28, 1982		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME David L. Sauers Funeral Home, Falls Church, Va.				25a. DATE REC'D. BY REGISTRAR Jan 3 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 4 6 9

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Beatrice Alvarez			2a DATE OF DEATH MONTH DAY YEAR 12/21/82			2b HOUR 4:40 M			
3 SEX Female		4 RACE Hispanic		5 DATE OF BIRTH MONTH DAY YEAR 7 31 18 64		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7b IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Panama City		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10 CITY OR TOWN OF DEATH Tokoma Park		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Screen Day Adventist				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY None	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE D.C.		13b CITY OR TOWN None		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS 846 Oglethorpe St. N.E.			
14 FATHER'S NAME FIRST MIDDLE LAST Martin Britia				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Petra Alvarez					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. unk		17 INFORMANT ADDRESS Elvirn Ho 8500 N.H. Ave. Sil. Spg. MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2849 IMMEDIATE CAUSE (a) CORAM negative sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Aplastic Anemia DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Rheumatoid arthritis, seizure disorder, diabetes									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from 11-28 , 19 82 , to 12-21 , 19 82 , that (1) we last saw the deceased alive on 12-21 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (1) did not view the body after death.									
22b SIGNATURE John Kujala				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 12-22-82	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Dec. 27, 82		23c NAME OF CEMETERY OR CREMATORY mt Olivet		23d LOCATION CITY OR TOWN COUNTY STATE Washington D.C.			
24 FUNERAL DIRECTOR NAME Vann and Williams				ADDRESS 4804 Ga. Ave. N.W.		25a DATE REC'D. BY REGISTRAR DEC 29 1982		25b REGISTRAR'S SIGNATURE John J. Canick	

BP

Montgomery Co.

George W. Allen

1892

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #8 Film G575 1/26/83 rc

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 4 7 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William M Ambush			2a. DATE OF DEATH MONTH DAY YEAR 12 31 82		2b. HOUR 5:25pm
3 SEX male	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 11 92		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 107 North Street 20850
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Ambush			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Coates		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-24-6586		17. INFORMANT ADDRESS SARAH AMBUSH (WIFE) SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2000 IMMEDIATE CAUSE (a) Right lower lobe PNEUMONIA + SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) HISTIOCYTIC LYMPHOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours 6 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) the hospital attended the deceased from August 19 82, to 12-31 19 82, that (I) the last saw the deceased alive on 12-31 19 82, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) may <input checked="" type="checkbox"/> did not view the body after death.					
22b. SIGNATURE Daniel Rosenblum		DEGREE MD		22c. DATE SIGNED 1/2/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM		22e. ADDRESS 10400 CONNECTICUT AV KENSINGTON, MD 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-4-83		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Fred. MD.					
24. FUNERAL DIRECTOR NAME George R Snowden		24b. ADDRESS 246 N. WASH. ST. Rockville, MD.		25a. DATE REC'D. BY REGISTRAR JAN 5 1983	
25b. REGISTRAR'S SIGNATURE John J. Canfield					

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 3 2 4 7 1	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph J. Argonis										ESTIMATED MONTH DAY YEAR 12 5 19 82	
3. SEX Male		4. RACE White		5. DATE OF BIRTH (MONTH DAY YEAR) July 22 1916		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner shoe store		12b. KIND OF BUSINESS OR INDUSTRY Shoe store	
13a. STATE Md. 20816				13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5630 Mass. Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST John Argonis						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Iaconis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 577-10-9068		17. INFORMANT ADDRESS Eleanor M. Argonis. Same as item 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										TITLE (SPECIFY)	
ACTUAL SIGNATURE <u>John Tamber</u>				M.D. _____ MEDICAL EXAMINER				DATE SIGNED <u>12-5-82</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>John Tamber</u>				ADDRESS <u>8218 Wisconsin Ave.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/9/1982		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u>						25a. DATE REC'D BY REGISTRAR <u>DEC 10 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>			
NAME <u>5130 Wisc. Ave., N.W. Wash., D.C.</u>						ADDRESS					

MEDICAL CERTIFICATION



May 11 1968

W. J. ...

...

...

John ...

to

...

...



...

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 4 7 2

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DELIA F BABCOCK			2a. DATE OF DEATH MONTH DAY YEAR Dec, 24, 1982			2b. HOUR 6:35 A				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JAN 11, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4218 BROOKFIELD DRIVE 20895	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS HAROLD A. BABCOCK SAME AS 13 HUSBAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Coronary heart disease DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-23 19 82 , to 12-24 19 82 , that (I) (we) lost saw the deceased alive on 12-24 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Steven K. Kaufman					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED DEC. 24, 1982		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN K. KAUFMAN					22e. ADDRESS 8830 CAMERON ST. SILVER SPRING, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 29, 1982		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE NANCY PULASKI KY.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					25a. DATE REC'D. BY REGISTRAR DEC 30 1982		25b. REGISTRAR'S SIGNATURE John J. Givish			

MEDICAL CERTIFICATION

2
9

1

STEWART K. KAUFMAN

DEC. 20, 1982

MAJCA

4330 CUTTON ST. SILVER SPRING, MD

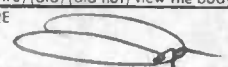
DEC. 24, 1982

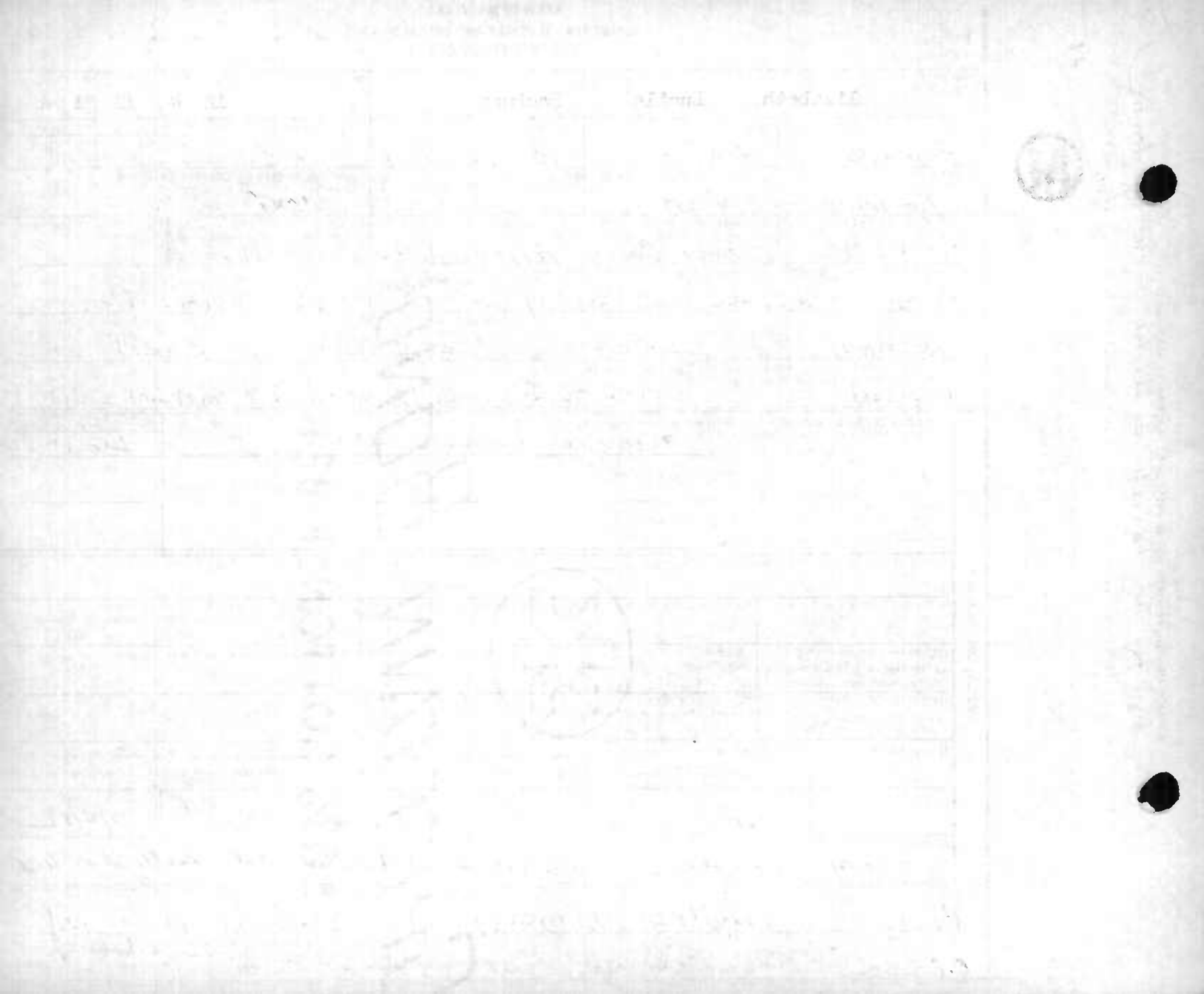
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 4 7 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Lucile Bachman			2a. DATE OF DEATH MONTH 12 DAY 4 YEAR 82			2b. HOUR 1 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 12 YEAR 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont CO. MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gov. Employee		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE UTAH		13c. CITY OR TOWN SAITLAKE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2625 Solar Dr.	
14. FATHER'S NAME 14a. FIRST Richard			14b. MIDDLE SPATES			14c. LAST KARN	
15. MOTHER'S MAIDEN NAME 15a. FIRST CLARA			15b. MIDDLE KARN			15c. LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 547-52-4672		17. INFORMANT JEANNE Immergluck SALT LAKE CITY			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal massive stroke</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Dec. 1982
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE  DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOUTH LERAGUL MD				22e. ADDRESS 7425 Arlington Rd Bethesda MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/6/82		23c. NAME OF CEMETERY OR CREMATORY MOUNTAIN		23d. LOCATION CITY OR TOWN COUNTY STATE BETHESDA MONTG. MD.	
24. FUNERAL DIRECTOR NAME G. C. Keltner				25a. DATE REC'D. BY REGISTRAR DEC 10 1982			
ADDRESS Barnesville MD 20835				25b. REGISTRAR'S SIGNATURE John J. Keltner			

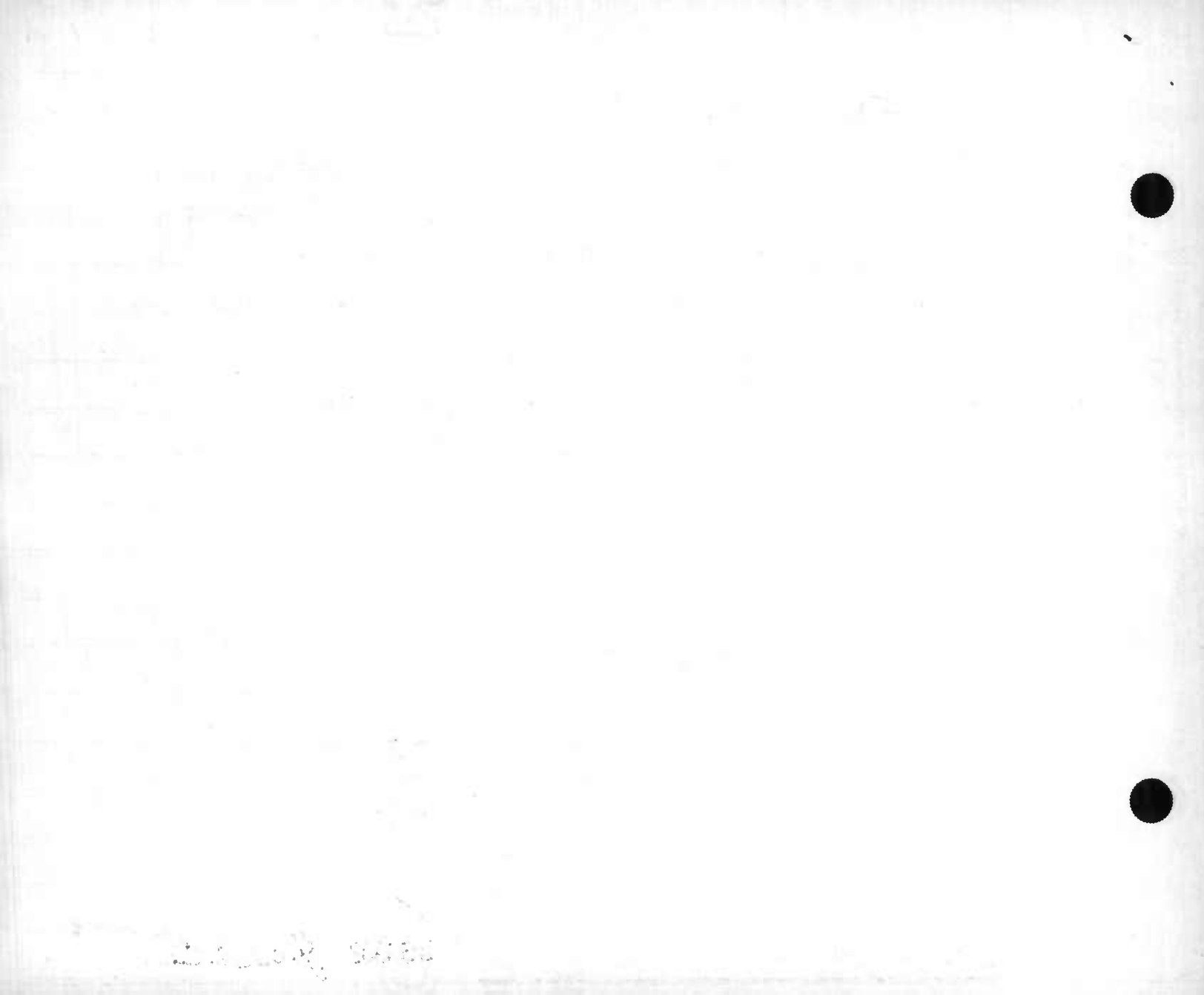


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 4 7 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ida Marie Bachman</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>12. 18-82</i>		2b. HOUR <i>1:15 A.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10. 19. 24</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>ownhome</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Wheaton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Sam Levinson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Butts</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			
17. SOCIAL SECURITY NO. <i>578 24 3231</i>		18. INFORMANT <i>Sol Bachman</i>		19. ADDRESS <i>13009 Bluhill Rd. Wheaton, Md. 20906</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metabolic acidosis</i> 1590 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Bowel carcinoma</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i> <i>6 mo</i> <i>4 yrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>Sept. 17, 1982</i> to <i>Dec. 17, 1982</i> , that (1) (we) lost saw the deceased alive on <i>17 Dec 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edward C. Gilbert</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12-18-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EDWARD C. Gilbert</i>		22e. ADDRESS <i>9801 Georgia Ave. Silver Spring</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-19-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King David Mem. Gar. Falls Church</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington D.C.</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey Inc.</i>		ADDRESS <i>8434 Ga. Ave. Sil. Spr. Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 23 1982</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the death certificate file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

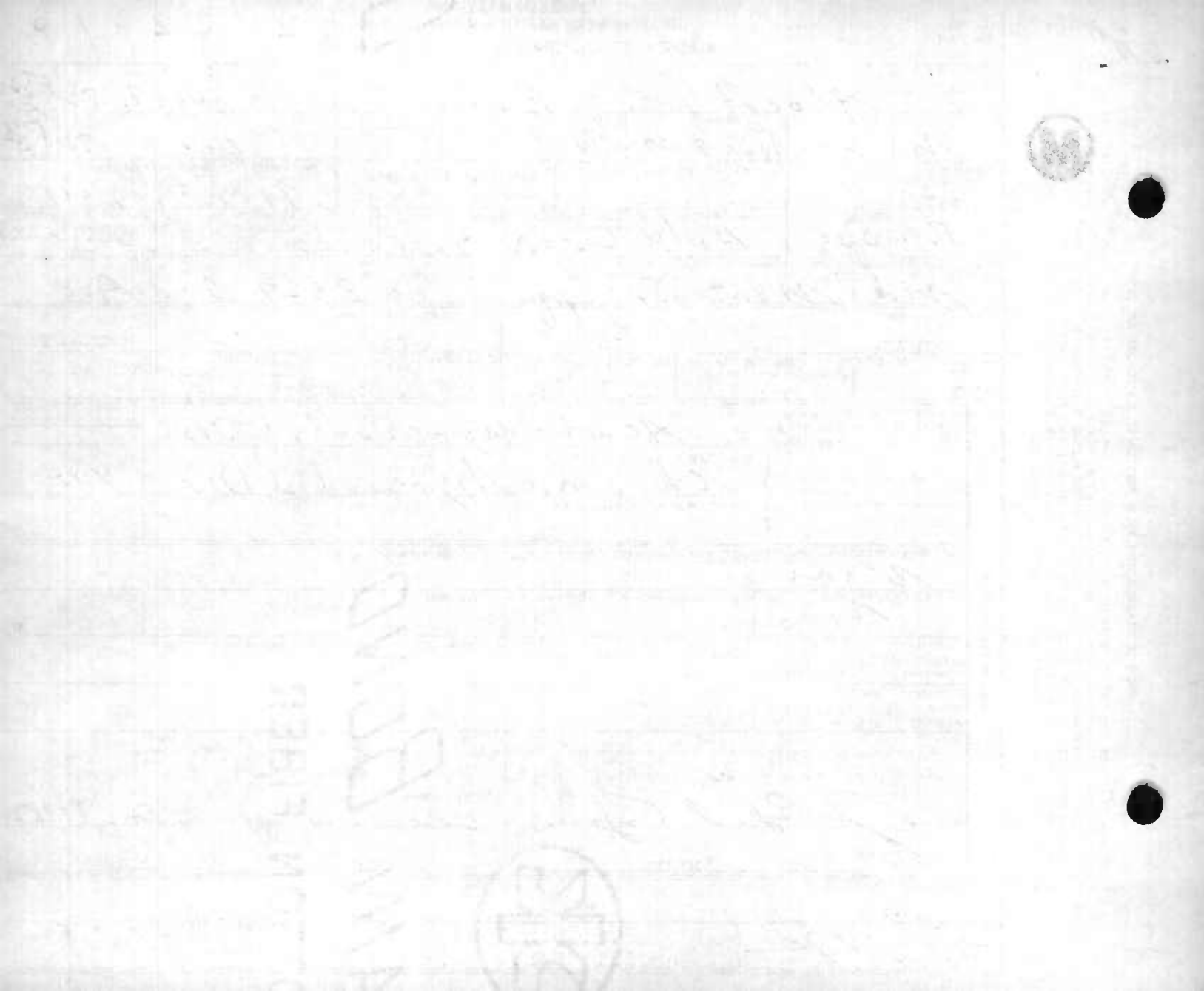
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 4 7 5
1. FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		FIRST JOSEPHINE E.	MIDDLE E.	LAST BAINES	2a. DATE OF DEATH MONTH DAY YEAR 12 23 82			2b. HOUR 8:55 AM		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DEC 17, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BETHESDA HEALTH CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3532 FISKE TERRACE 20906		
14. FATHER'S NAME FIRST MIDDLE LAST FRANZ FRIEDRICH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA WIEHAUSEN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS ANNA M. McINTIRE SAME AS 13 DAUGHTER						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4379 IMMEDIATE CAUSE (a) Terminal cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) - DUE TO, OR AS A CONSEQUENCE OF (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE -						
22a. I certify that (I) (this hospital) attended the deceased from 1979 , 19____, to 12/23/82 , 19____, that (I) (we) last saw the deceased alive on November 19, 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE  MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/23/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSOOTH LEKAGUL MD		22e. ADDRESS 7425 arlington Rd Bethesda Md 20814								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/24/82		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE 						
26. ADDRESS 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901										

DEC 5 1965

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 2 4 7 6	
1. DECEASED NAME (TYPE OR PRINT) Albert E. Baker						2a. DATE KNOWN OF DEATH MONTH DAY YEAR Dec 7, 1982					
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR June 9 1909	6. AGE (IN YEARS) (LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Dec 7, 1982			7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Sil. Spg.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemical Eng.				12b. KIND OF BUSINESS OR INDUSTRY Wash. Board of Trade	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Mont 13c. CITY OR TOWN Sil. Spg.						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8927 2nd Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Lee Baker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myra Dennis				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) ---			
16b. SOCIAL SECURITY NO. 214-10-9622				17. INFORMANT Mary E. Bakersil				ADDRESS 8927 - 2nd Avenue Sil. Spr., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Chronic Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF (c) 4 yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D. Dec				MEDICAL EXAMINER DATE SIGNED Dec 7 1982			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME				ADDRESS Silver Spring, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/8/82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.			
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey		ADDRESS Sil. Spr., Md.		25a. DATE REC'D BY REGISTRAR DEC 13 1982		25b. REGISTRAR'S SIGNATURE John J. Church					

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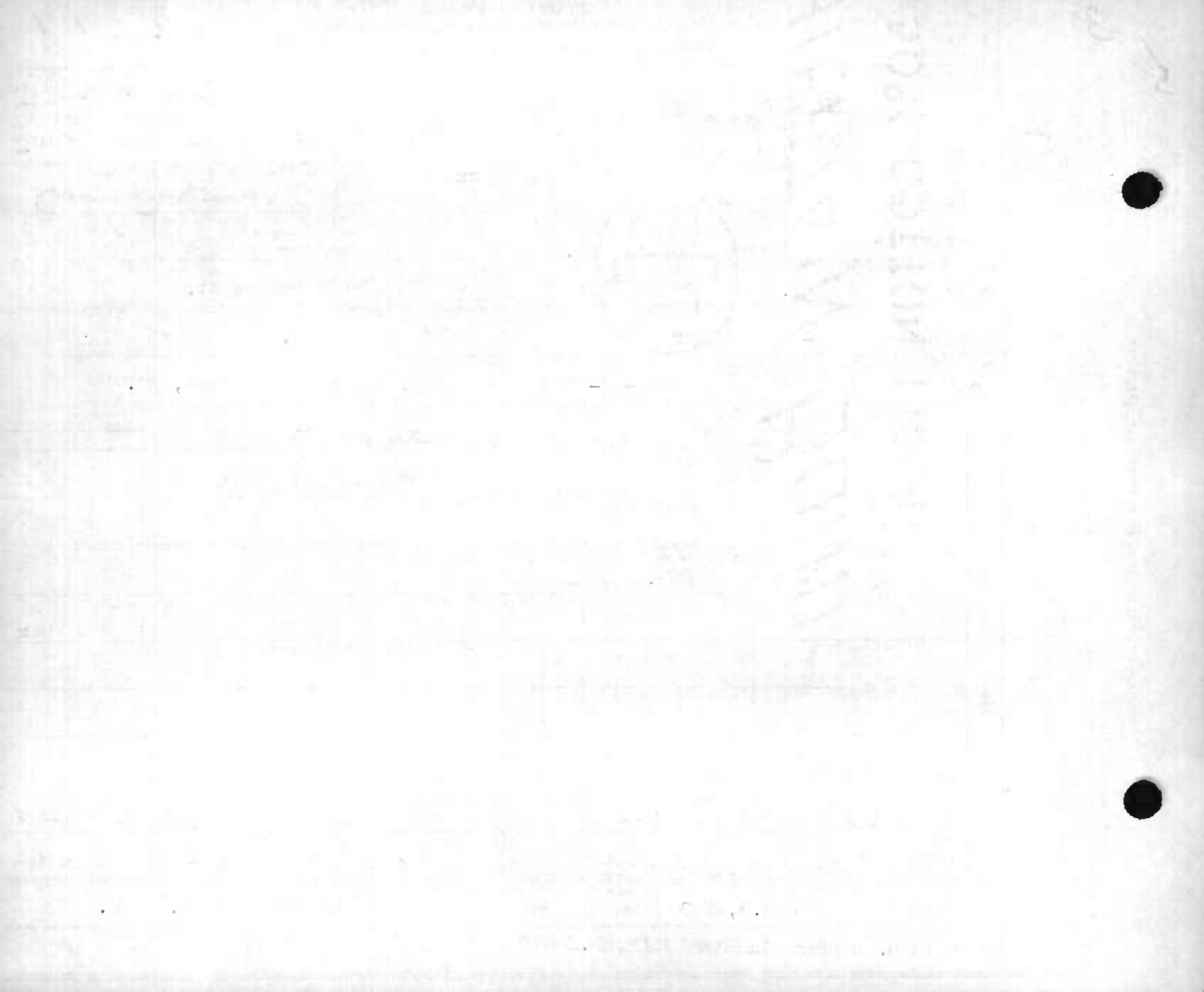


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5 2 3 2 4 7 7			
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HILBERT McCoy BAKER						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 30 19 82 2b. HOUR 2 30 AM									
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4-28-29 53 YRS		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 12-30-82 19 700 PM		2d. HOUR 7 00 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 602 Monroe St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Janitor				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland						13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 602 Monroe St.			
14. FATHER'S NAME FIRST MIDDLE LAST Raymond - Baker						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda J. Baker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 230-28-8302				17. INFORMANT ADDRESS Randy A. Baker Brentwood, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardiac arrest. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) } PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Cranial Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE [Signature] M.D.						TITLE (SPECIFY)						DATE SIGNED 12-30-82			
EXAMINER'S NAME (TYPE OR PRINT) John Tauber						ADDRESS 8218 W. Conson Ave.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 3, 1983				23c. NAME OF CEMETERY OR CREMATORY Seals Farm				23d. LOCATION CITY OR TOWN COUNTY STATE Etchison Mont. Md.			
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879								25a. DATE REC'D. BY REGISTRAR JAN 5 1983				25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE BANKS					2a. DATE OF DEATH MONTH DAY YEAR HOUR 12/27/1982 12:53 PM				
3. SEX FEMALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 20 1918		6. AGE (IN YEARS LAST BIRTHDAY) YRS 64		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21001 Apt. E, 107 Hanover Street	
14. FATHER'S NAME FIRST MIDDLE LAST Roy Taylor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Banks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 212-26-7862		17. INFORMANT ADDRESS Bernard Dorsey, Apt. E, 21001 Hanover Street, Aberdeen, Md.			
18. CAUSE OF DEATH (Enter only one cause per line, or (1), (2), and (3). PART I. DEATH WAS CAUSED BY: 4100 Acute Myocardial Infarction									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									(b) DUE TO, OR AS A CONSEQUENCE OF
									(c) DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/1/82 to 12/27/82 , that (I) (we) last saw the deceased on 12/27/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Mark H. Elk				DEGREE PHYSICIAN				22c. DATE SIGNED 12/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK H. ELK				22e. ADDRESS 9801 Georgia Ave, Silver Spring, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Maryland			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A.,				ADDRESS Aberdeen, Md. 21001-3399		25. SIGNATURE OF REGISTRAR [Signature]			

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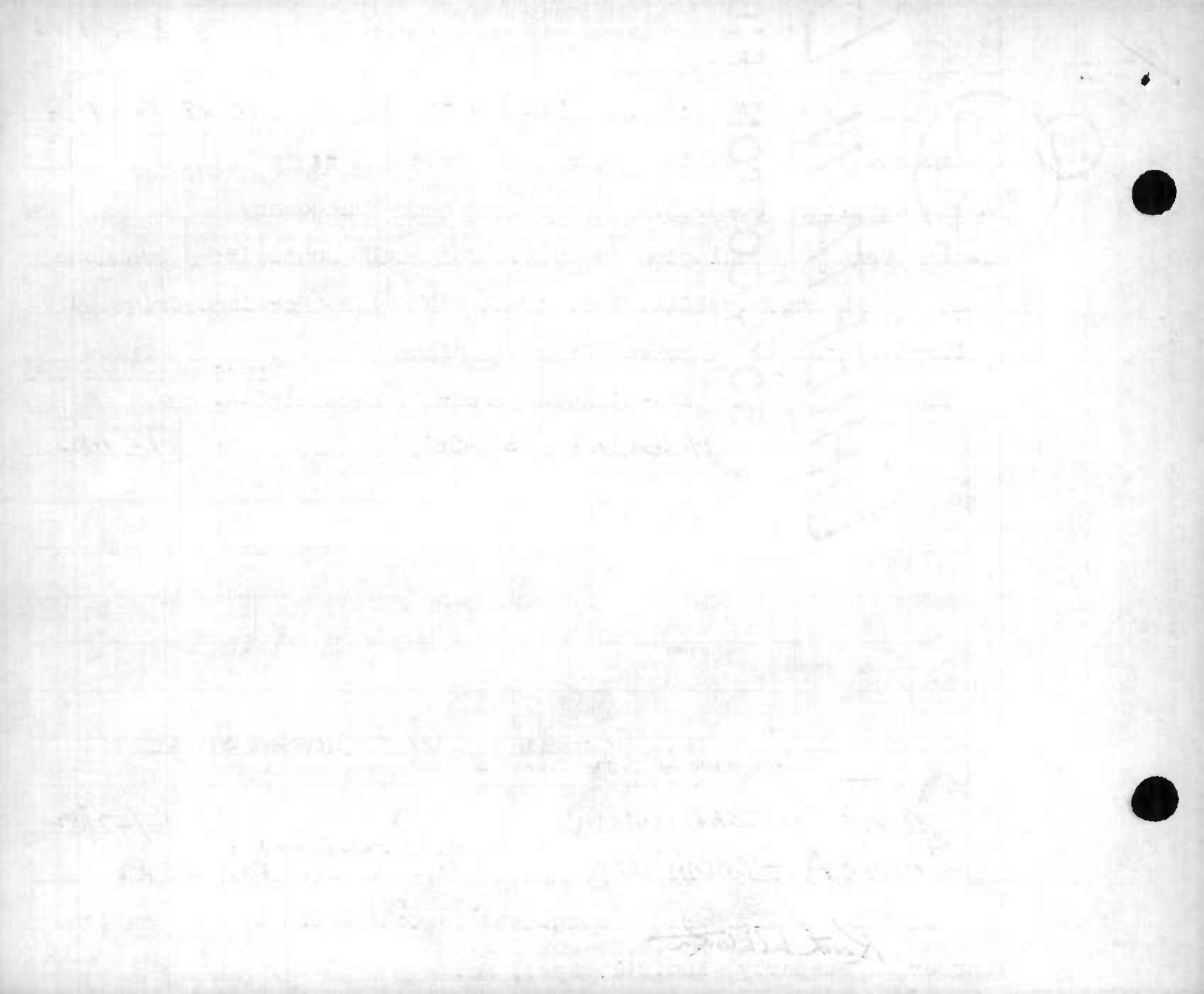
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 4 7 9			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Cheryl Ann Bartlett								12 27 82					7 " A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		9 15 1958		24 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
North Carolina		U. S. A.				Montgomery						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Takoma Park		Washington Adventist Hospital		Housewife		Own Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		Montgomery		Sil. Spr.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1005 Merrimac Drive 20903					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
Charles Daniel		Diana V. Price		No		219-84-1602		Walter E. Bartlett					
				---				1005 Merrimac Dr.					
								Sil. Spr., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HODGKINS DISEASE</u> 2019 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mos			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from <u>OCTOBER</u> 19 <u>81</u> , to <u>DECEMBER 27</u> 19 <u>82</u> , that (we) lost saw the deceased alive on <u>DECEMBER 25</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
James C. Brown				12/27/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
JAMES A. BROWN, MD		6125 BEECHST RD HYATTSVILLE MD 20782											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		12/30/82		George Washington Cemetery		Adelphi,						Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Warner E. Pumphrey, Inc.		3 1983		JAN									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 4 8 0

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harry B Batchelor			2a. DATE OF DEATH MONTH DAY YEAR December 24, 1982		2b. HOUR 7:45 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 8 1918	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 508 Albany Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR-ACCT. PRG		12b. KIND OF BUSINESS OR INDUSTRY DRAFTING
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 508 Albany Avenue
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL P. BATCHELOR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES HALL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 239-12-1977		17. INFORMANT ADDRESS Mrs. Eloise M. Batchelor above	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer - lymphatic Anus 1991 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 1 year					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/22 to 12/24 , that (we) last saw the deceased alive or above (I) (we) (did not) view the body after death.					
22b. SIGNATURE Benjamin H. H. H. H.		DEGREE		22c. DATE SIGNED 12/29/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN H. H. H. H.		22e. ADDRESS 3720 Franquet Ave, Ken, Md 20815			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/1982	23c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW		23d. LOCATION CITY OR TOWN COUNTY STATE FRODOCK 2 VIRGINIA
24. FUNERAL DIRECTOR NAME William W. Walters		25a. ADDRESS 254 Carroll St, Takoma Fun'l Home, Inc. N.W., Wash. D.C.		25b. DATE RECEIVED BY REGISTRAR DEC 29 1982	

BP

Takoma Park, Inc., Wash., D.C.

Virginia

FOOT COTTON



27-12-1977 Mrs. Eloise A. Batchelor above

27-12-1977 Mrs. Eloise A. Batchelor above

27-12-1977 Mrs. Eloise A. Batchelor above

27-12-1977 Mrs. Eloise A. Batchelor above

27-12-1977 Mrs. Eloise A. Batchelor above

27-12-1977 Mrs. Eloise A. Batchelor above

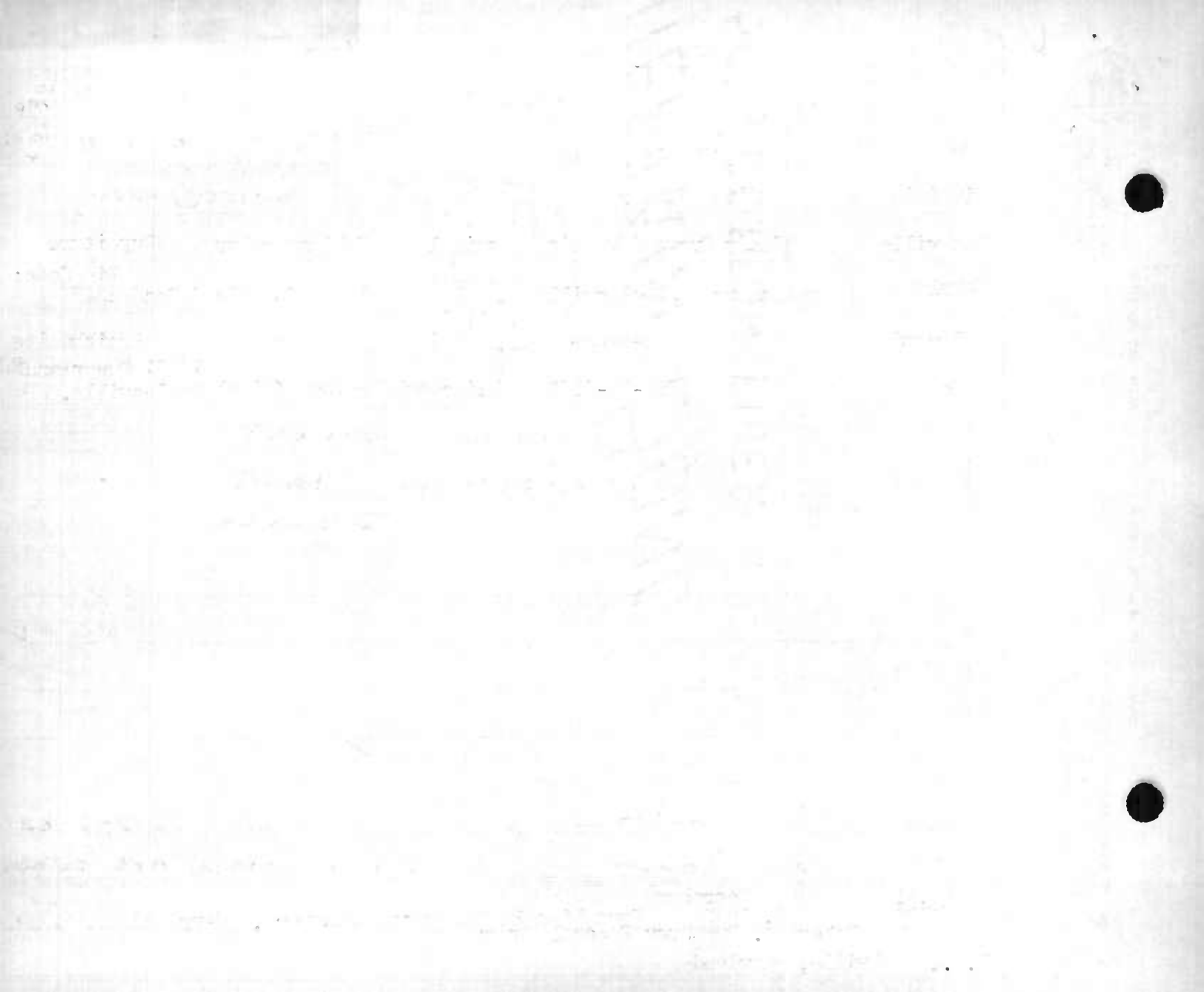
27-12-1977 Mrs. Eloise A. Batchelor above

1. DECEASED NAME (TYPE OR PRINT) <i>Gertrude F. Baum</i>		20. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> <i>Dec 22 1982</i>		26. HOUR 11:00 AM	
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 27 1963</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>63 YRS.</i>	7. IF UNDER 1 YR. MONTHS DAYS <i>0 0</i>	8. IF UNDER 24 HRS. HOURS MIN. <i>0 0</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Actuary (Ret.)</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>US Govt.</i>	
10. CITY OR TOWN OF DEATH <i>St. Louis</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Heart Cross Hosp</i>		12c. STREET ADDRESS <i>13301 Sherwood Forest Dr</i>	
13a. STATE <i>Mo</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>St. Louis</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Baum</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Giselle Kurte</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>unknown</i>		17 INFORMANT <i>Silver Spring, Md. Forest, Dr.</i>		17. JEROME PODELL; 13301 SHERWOOD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4291 Acute Myocardial Dm</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last: (b) <i>Chronic Myocardial Dm</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>None</i>					
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion TITLE (SPECIFY) ACTUAL SIGNATURE <i>John S. Rogers</i> M.D. <i>Dep.</i> MEDICAL EXAMINER DATE <i>Dec 22 1982</i> EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS, M.D.</i> ADDRESS _____					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>12-24-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee Crematory</i>	
23d. LOCATION CITY OR TOWN <i>Washington, D.C.</i>		23e. COUNTY <i>D.C.</i>		23f. STATE <i>D.C.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Danzansky-Goldberg Chapels; 1170 Rockville Pike</i>		25. DATE REC'D. BY REGISTRAR <i>DEC 28 1982</i>		26. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Joseph Beetham						2a. DATE KNOWN OF DEATH MONTH 12 DAY 1 YEAR 1982		2b. HOUR 10:29 PM			
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 6 DAY 14 YEAR 06	6. AGE (IN YEARS) (LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD MONTH 12 DAY 1 YEAR 1982		2d. HOUR 10:29 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker		12b. KIND OF BUSINESS OR INDUSTRY Furniture			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Poolesville						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14951 Sugarland Road Zip Code: 20873			
14. FATHER'S NAME FIRST Edward MIDDLE Beetham LAST Beetham						15. MOTHER'S MAIDEN NAME FIRST Edith MIDDLE Ann LAST Braithwaite					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 577-12-9158		17. INFORMANT ADDRESS 14951 Sugarland Rd Elizabeth Beetham (Wife) Poolesville, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Arterio Sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tauber M.D.						TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED 12-2-82	
EXAMINER'S NAME (TYPE OR PRINT) John Tauber						ADDRESS 8218 Wisconsin Ave Bethesda					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE December 6, 1982		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood COUNTY Maryland STATE					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes P.A., Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR DEC 6 - 1982		25b. REGISTRAR'S SIGNATURE John J. Smith			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WALTER S. BENCHOFF			20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 28 1982			21. HOUR 10:54 AM				
2. SEX M	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 12 15 00	6. AGE (IN YEARS) LAST BIRTHDAY 82 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	22. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 28 1982			23. HOUR 10:54 AM	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY				
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing		
13a. STATE PA			13b. COUNTY Franklin		13c. CITY OR TOWN BLUE RIDGE SUMMIT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11735 FURNACE RD	
14. FATHER'S NAME FIRST MIDDLE LAST John Benchoff			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Izer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Margaret Benchoff, 11738 Furnace Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) CORONARY ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDEX										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ---										
19a. DATE OF OPERATION ---			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? ---				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH ---			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:30 AM 12 28 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) CHEST PAIN + CARDIAC ARREST					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ROUTE 270 CLARKSBURG MONT. MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Francis C. Mayle			TITLE (SPECIFY) Dy. M.D.			MEDICAL EXAMINER		DATE SIGNED 12/28/82		
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C. MAYLE			ADDRESS 800 W. SCRIBNER AVE. POTOMAC MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-31-82		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Fairfield, Adams, PA			
24. FUNERAL DIRECTOR John J. Monahan					ADDRESS 27 East Main St., Fairfield, PA		25a. DATE REC'D. BY REGISTRAR 1 JAN 5 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
NORTON A. BENFER				DECEMBER 11 82		5:05 P.M.			
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE		White		MONTH DAY YEAR		74 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		U. S. A.				Montgomery CTY MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
KENSINGTON, MD.		KENSINGTON GARDENS Nursing Home		Truck Driver		Berlo Vend-ing			
13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Prince Geo. Mt.		Rainier		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3336 Chauncey Place	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Charles Benfer		Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Unknown		579-07-0184		Carolyn A. Benfer		718 Northampton Dr. Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		5715 IMMEDIATE CAUSE (a)		Hepatic failure with		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		Hepato-renal syndrome		6 mox			
(c)		due to cirrhosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/11 1982 to 12/11 1982, that (we) (we) saw the deceased (above), and that in my (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
BARRY N. ROSENBAUM		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				12/12/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
BARRY N. ROSENBAUM		3720 FARRAGUT AVE. KENSINGTON, MD. 20895							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/14/82		Ft. Lincoln Cemetery		Brentwood, Maryland			
24. FUNERAL DIRECTOR		P.O. Box 7428		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc.		Sil. Spr., Md.		DEC 15 1982		John J. Canich			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

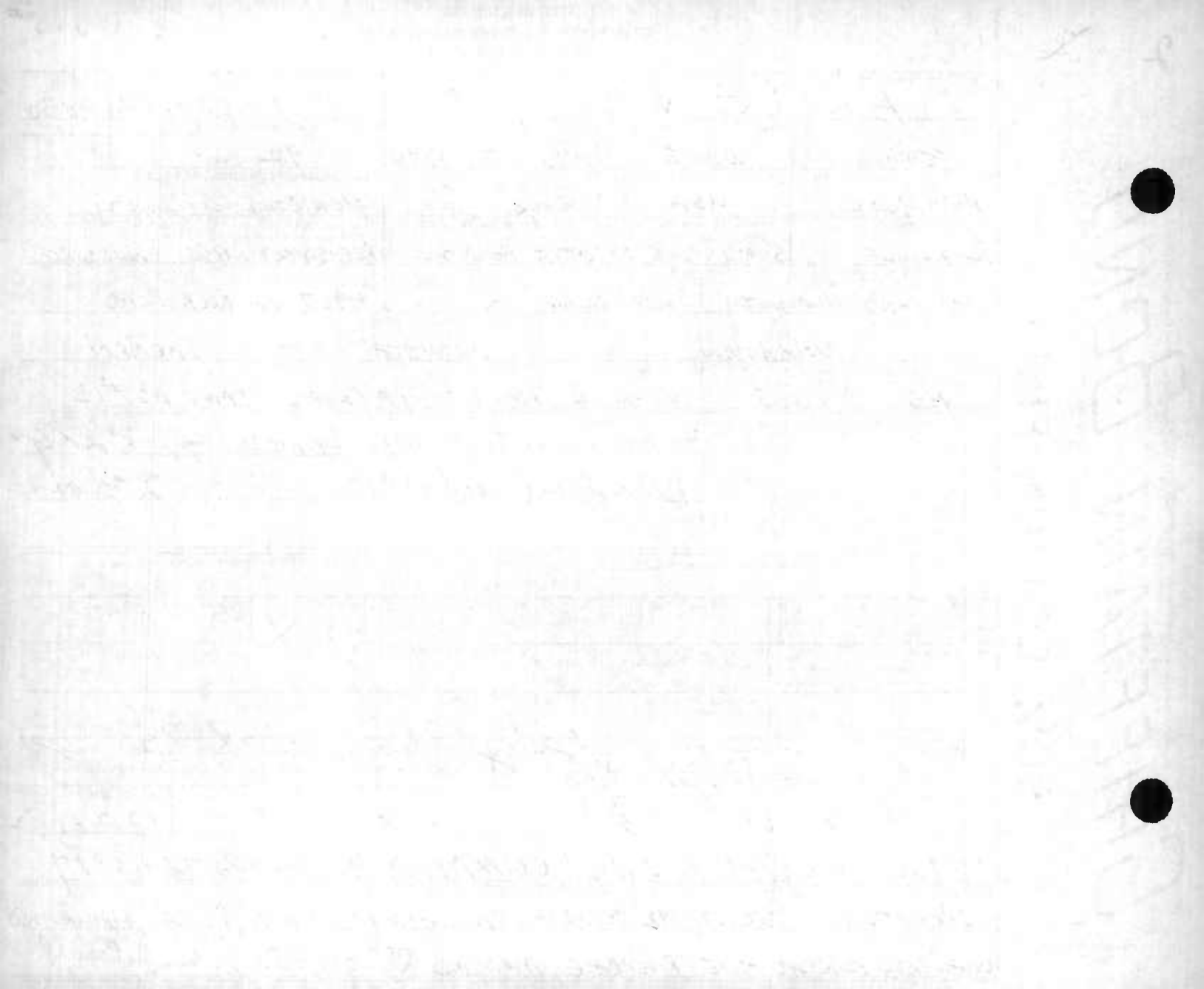
8 2 3 2 4 8 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALICE V. BERGER		2a. DATE OF DEATH MONTH 12 DAY 24 YEAR 82 2b. HOUR 0830	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH AUG. DAY 7 YEAR 1890	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REGISTERED NURSE	12b. KIND OF BUSINESS OR INDUSTRY NURSING
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN	15. MOTHER'S MAIDEN NAME FIRST AUGUSTA MIDDLE - LAST FARNAN	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WWI	
16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS MRS. DOROTHY A REGAL SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO-INTESTINAL Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Duodenal ulcer DUE TO, OR AS A CONSEQUENCE OF (c) 2 years			APPROXIMATE INTERVAL BETWEEN ONSET OF ILLNESS AND DEATH 5 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from July 1982 to 12/24/82 , that (I) (we) lost view the deceased alive on 12/24/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) THOS G. WARD	22c. ADDRESS 6116 ROBINWOOD, BETHESDA MD 20817	22d. DATE SIGNED 12/24/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE DEC. 27, 1982	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PG. CO. MARYLAND
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME ADDRESS RIVERDALE, MARYLAND	25a. DATE REC'D. BY REGISTRAR DEC 30, 1982 25b. REGISTRAR'S SIGNATURE John J. Connel		

MEDICAL CERTIFICATION

29



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be reported to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 4 8 6			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) ELEETHEER L. BESLEY				2a. DATE OF DEATH MONTH DAY YEAR 12/16/82			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 14 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Asbury Methodist Village		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adm. Assistant		12b. KIND OF BUSINESS OR INDUSTRY Accounting	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 20877 13b. COUNTY Montgomery 13c. CITY OR TOWN Gaithersburg				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 301 Russell Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Jerome Besley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Woodward			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-03-1004		17. INFORMANT ADDRESS Michigan. 48655 Ethel Pillar, 11780 Andrews Rd., St. Charles			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordiorespiratory arrest 1890 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Under nutrition (c) Renal Adenocarcinoma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 min Coma. 2 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Malabsorption							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from May 3 1982 , to Dec 16 1982 , that (1) (we) last saw the deceased alive on Dec 15 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James R. Moore Jr. MD				DEGREE MD		22c. DATE SIGNED 12-16-82	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Moore Jr.				22c. ADDRESS 207 Brooks Ave Gaithersburg Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/18/1982		23c. NAME OF CEMETERY OR CREMATORY Lewinsville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE McLean Virginia	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR DEC 20 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

BP

1961-1962

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE MEDICAL EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 4. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VRA15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32487	
1. DECEASED NAME (TYPE OR PRINT) AUGUSTA M. BINNIX										2a. DATE KNOWN OF DEATH 12 10 1982	
3. SEX Fe		4. RACE CAUC		5. DATE OF BIRTH May 6, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 12 10 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manufacturer		12b. KIND OF BUSINESS OR INDUSTRY Garment	
13a. STATE MD 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 8484 16th St (20910)											
14. FATHER'S NAME (FIRST MIDDLE LAST) George Rossignol						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Louise Cope					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577-36-9936		17. INFORMANT 9835 Singleton Dr. Douglas C. Jones Bethesda, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DIS. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs YRS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SMALL BOWEL OBSTRUCTION											
19a. DATE OF OPERATION 11/27/82				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? INTERTROCHANTERIC FRACTURE LEFT HIP				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH 95 P.M. 11 20 1982 FELL AT HOME				21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 95 P.M. 11 20 1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL AT HOME			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) 8484 16th St SILVER SPRING MONT. MD			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Francis C. Mayle						TITLE (SPECIFY) Asst		MEDICAL EXAMINER		DATE SIGNED 12/11/82	
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle						ADDRESS 8200 Wisconsin Ave Bethesda MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec 15, 1982		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.				23d. LOCATION (CITY OR TOWN COUNTY STATE) Washington, D.C.	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814						25a. DATE REC'D. BY REGISTRAR DEC 17 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			

DEC 17 1985

John G. Smith

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Ethel

Raye

Bishop

2b. DATE KNOWN OF
DEATH MATED ☒ 12 22 1982 2b. HOUR
M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

Feb. 1, 1922

6. AGE (IN YEARS)

60 YRS.

IF UNDER 24 YRS.

MONTHS DAYS HOURS MIN.

2c. DATE
PRONOUNCED
DEAD 1 2 1983 2d. HOUR
M7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Douglas Cty., Mo.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County, MD.

10. CITY OR TOWN OF DEATH

Rockville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12630 Vier Mill Road

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Realtor-Saleslady Merrill Lynch

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland

13b. CITY OR TOWN Montgomery

13c. CITY OR TOWN Rockville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS

12630 Vier Mill Rd. Apt. 117

14. FATHER'S NAME

FIRST Isiah

MIDDLE Porter

LAST Henson

15. MOTHER'S MAIDEN NAME

FIRST Hattie

MIDDLE Martha

LAST Hodge

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

None

16b. SOCIAL SECURITY NO.

558-32-4663

17. INFORMANT

Mrs. Helen Raye Snider, Ellijay, Ga. 223A

ADDRESS Route 4, Box 30540.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

2500

IMMEDIATE CAUSE (a)

Diabetes mellitus

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opiniondeath resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

TITLE (SPECIFY)

Deputy Chief MEDICAL EXAMINER

DATE
SIGNED 1/3/83EXAMINER'S NAME
(TYPE OR PRINT)

Thomas D. Smith, M.D.

ADDRESS

111 Penn St. Balto., MD.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Cremation

23b. DATE

Jan. 4, 1983

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Crematory Suitland P.G. Cty., Md.

23d. LOCATION
CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR

W.W. CHAMBERS CO. 8655 Ga., Ave., S.S. Md.

25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE)

JAN 10 1983 John J. Lewis

20910

(M)

NOTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (Type or print) ROBERT FOREST BLACKBURN					2a. DATE OF DEATH MONTH DAY YEAR 12 20 82 6 ²⁸ P.M.				
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 31, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7b. HOUR 6²⁸ P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH 1. akoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Plumbing Contr.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4500 Samar Street	
14. FATHER'S NAME FIRST MIDDLE LAST Archie Blackburn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Jane B. rock					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-14-9301		17. INFORMANT ADDRESS Lillian I. Burton (Dau) College Hgts, Dste					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days 2 weeks 10 yrs +									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MAY , 19 70 , to Dec 20 , 19 82 , that (I) (we) last saw the deceased alive on Dec 20 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert B. Irey				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-20-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B. IREY				22e. ADDRESS 11161 New Hampshire Ave Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 23, 1982		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo's Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons, PA Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE John E. Canfield			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 4 9 0	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Couise W. Blakeley					2a. DATE OF DEATH MONTH DAY YEAR December 18, 1982		2b. HOUR 10:25 P.M.				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 8, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Security Firm			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13404 Oriental Court (20853)			
14. FATHER'S NAME FIRST MIDDLE LAST Robert William Wood					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marguerite Shanklin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 569-38-8464		17. INFORMANT Marguerite T. Isman					17a. 13404 Oriental Court Rockville, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated diverticulum										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) peritonitis + multiple intra-abdominal abscesses											
DUE TO, OR AS A CONSEQUENCE OF (c) Diverticulitis											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive lung disease; Diabetes											
19a. DATE OF OPERATION 12-4-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated colonic diverticulum				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from April 1979 to 12-18-82 , that (I) (we) last saw the deceased alive on 12-18-82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)											
22b. SIGNATURE Jason Cooper, M.D.					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-19-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jason Cooper, M.D.					22e. ADDRESS 8830 CAMERON STREET SILVER SPRING, MD 20910						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec 19, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia					
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P.A., ROCKVILLE, MARYLAND					25. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE DEC 23 1982						

MEDICAL CERTIFICATION

100 23785

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 4 9 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Chester F. Bletsch			2a. DATE OF DEATH MONTH DAY YEAR 12 14 82			2b. HOUR 1005 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 11 1898		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION Dir. of Public Rela. Milk Producer's Assoc.	
13a. STATE --		13b. COUNTY --		13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick H. Bletsch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie C. Gibson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 1		17. INFORMANT ADDRESS Dorothy H. Bletsch-wife-(same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 3310 IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) ALZHEIMER'S DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: gastrointestinal bleeding - is chronic bowel disease							
19a. DATE OF OPERATION --		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED --		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) --			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) --		21f. LOCATION STREET CITY OR TOWN COUNTY STATE --			
22a. I certify that (I) (this hospital) attended the deceased from 7/82, 19, to 12/14, 1982, that (I) (we) lost saw the deceased alive on 12/14, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joel Mulhouser MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Mulhouser, MD				22e. ADDRESS 916 19th. Street, NW Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-17-1982		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.	
24. FUNERAL DIRECTOR NAME ADDRESS HINES/RINALDI F.H. 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD.							
25a. DATE REC'D. BY REGISTRAR DEC 16 1982				25b. REGISTRAR'S SIGNATURE John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 4 9 2			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) EVELINE HOCKING BOUCHER				2a. DATE OF DEATH MONTH DAY YEAR 12 5 82		2b. HOUR 10:57 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 13, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10900 Bucknell Dr. #633		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST William G. Hocking				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth A. Allen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-42-4534		17. INFORMANT ADDRESS Silver Spring Md. 20904			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) STROKE DUE TO, OR AS A CONSEQUENCE OF (c) 1 DAY				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONGESTIVE HEART FAILURE; EMPHYSEMA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/4 , 19 82 , to DEC 5 , 19 82 that (I) (we) lost above (I) (we) (d-d) (d-d) view the body after death.							
22b. SIGNATURE <i>Richard P. Delaney</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/5/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD P. DELANEY MD				22e. ADDRESS 4323 HAVARD ST SIL SPRG, MD. 20904			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec/6/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Co., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Silver Spring, Maryland				25a. DATE REC'D BY REGISTRAR DEC 8 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

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Chambers & Sons, Silver & Gold, London

London, 10th Dec 1914

Richard P. Deane, MD, 433 Howard St, New York

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 2 3 2 4 9 3		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			2b. HOUR				
MARY E BOWE			DEC. 12, 1982 8:00 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Dec. 9, 1912		70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Montgomery County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Potomac Nursing Home		Housewife		Home	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Montgomery		Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
William - Souder				Elizabeth - Arnold			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		None		Dorothy Kahn (Sister) Same as # 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cerebrovascular accident</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4360							2 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular disease</u>							5 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a-							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/1/12 to 12/12/82, that (I) (we) lost							
saw the deceased alive on 12/12/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Myron L. Lenkin				MD		12/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
MYRON L. LENKIN				2309 SHOREFIELD RD WHEATON, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		Dec/14/82		Cedar Hill Crematory		Suitland, P.G. Co., Maryland	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Chambers Funeral Home Silver Spring, Maryland				DEC 16 1982		John J. Carver	

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 4 9 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Mary Alice Bowling				2a. DATE OF DEATH MONTH DAY YEAR December 26, 1982			
3. SEX Female				2b. HOUR 6:10PM			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 16 18		6. AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Ashton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Tucker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary TALBERT Talbert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 579-12-7202		17. INFORMANT THOMAS PAUL BOWLING, SR. SAME AS 13 HUSBAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYELOMA 2030 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April , 19 81 , to Dec 26 , 19 82 , that (I) (we) last saw the deceased alive on Dec 26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eugene P. Flannery, M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 27 Dec 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene P. Flannery, M.D.				22e. ADDRESS 1811 Prince Philip Drive Olney, Maryland 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/29/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR FRANCIS J. COLLINS NAME ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR JAN 6 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32495	
1. DECEASED NAME (TYPE OR PRINT) Samuel LeFevre Boyer										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 12-8-82 MATED <input type="checkbox"/> 12-8-82 19	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-29-43		6. AGE (IN YEARS) LAST BIRTHDAY 43 YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-8-82 19	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Letter Carrier		12b. KIND OF BUSINESS OR INDUSTRY Postal	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8337 Walter Martz Rd.		21701	
14. FATHER'S NAME FIRST MIDDLE LAST Lester Walter Boyer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Amanda DeLaughter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Vietnam		17. INFORMANT Jeanette Boyer		ADDRESS 8337 Walter Martz Rd. Frederick, MD 21701			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4241 IMMEDIATE CAUSE (a) Cardiac arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: aortic stenosis (b) aortic stenosis DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tauber M.D.						TITLE (SPECIFY)		DATE SIGNED 12-8-82		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) John Tauber						ADDRESS 8218 Wisconsin Ave.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/11/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.	
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer ADDRESS 1621 opossumtown Pike, Frederick, Md.						25a. DATE REC'D. BY REGISTRAR DEC 16 1982		25b. REGISTRAR'S SIGNATURE John J. Lough			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 3 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - STATE REGISTRAR		REG. NO.		8 2 3 2 4 9 6					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emily D. Branch				2a. DATE OF DEATH MONTH DAY YEAR December 21, 1982		2b. HOUR 11:50 AM			
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20877 501 South Frederick Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Daughtry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Eley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 277-68-6065		17. INFORMANT Daughter same as 13e	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a anemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 79 12/21 82 0					
22a. I certify that (I) (this hospital) attended the deceased from 12/21/82 to 12/21/82, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Cheryl Winchell				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cheryl Winchell				22e. ADDRESS 19241 Montgomery Village Ave					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 23, 1982		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Norfolk Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey P.A., Rockville, Maryland				24b. ADDRESS Funeral Homes,		25a. DATE REC'D. BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE John J. Smith	

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4-82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		3 2 4 9 7	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTARA H. BRANNOCK			
3. SEX Female		4. RACE Cauc.	
5. DATE OF BIRTH MONTH DAY YEAR April 26 1975		6. AGE (IN YEARS) LAST BIRTHDAY 7 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? United States	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9512 Nowell Drive	
13a. STATE Maryland		13b. CITY OR TOWN Montgomery	
14. FATHER'S NAME FIRST MIDDLE LAST William C. Brannock		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda J. Balentine	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None	
17. INFORMANT Grandmother 5015 Battery Lane Janice C. Pokras Bethesda, Md 20814		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thermal injuries 8903 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:20AM 12-19-82	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) caught in housefire			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home	
21f. CITY OR TOWN 9512 Nowell Drive		21g. STATE Bethesda, Maryland	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE Margaret De Hull		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 21, 1982	
23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A., Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 23 1982	
25b. REGISTRAR'S SIGNATURE John J. Canfield			

Handwritten text at the bottom left, possibly a signature or date: "Handwritten text - 1854"



Vertical text or stamp in the lower middle section, possibly reading "DND" or similar characters.

Vertical text or stamp to the left of the "DND" stamp, possibly reading "NO 11" or similar characters.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 4 9 8	
1. DECEASED NAME (TYPE OR PRINT) WILLIAM C. BRANNOCK						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12-19-82		2b. HOUR AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan 9 1948		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.		7c. DATE PRONOUNCED DEAD 12-19-82		7d. HOUR 8AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9512 Nowell Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Massage Therapist		12b. KIND OF BUSINESS Spa	
13a. STATE Maryland				13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9512 Nowell Drive 20817	
14. FATHER'S NAME FIRST MIDDLE LAST Harold S. Brannock						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janice C. Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-46-5751		17. INFORMANT mother 5015 Battery Lane Janice C. Pokras Bethesda, Md 20814					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8902 IMMEDIATE CAUSE (a) Smoke and soot inhalation Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 6:20AM 12-19-82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) caught in housefire					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9512 Nowell Drive Bethesda, Maryland					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Margareta A. Koroll				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12-20-82			
EXAMINER'S NAME (TYPE OR PRINT) Margareta A. Koroll, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Dec. 21, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Humphrey				ADDRESS Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 23 1982			

100-442007-104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

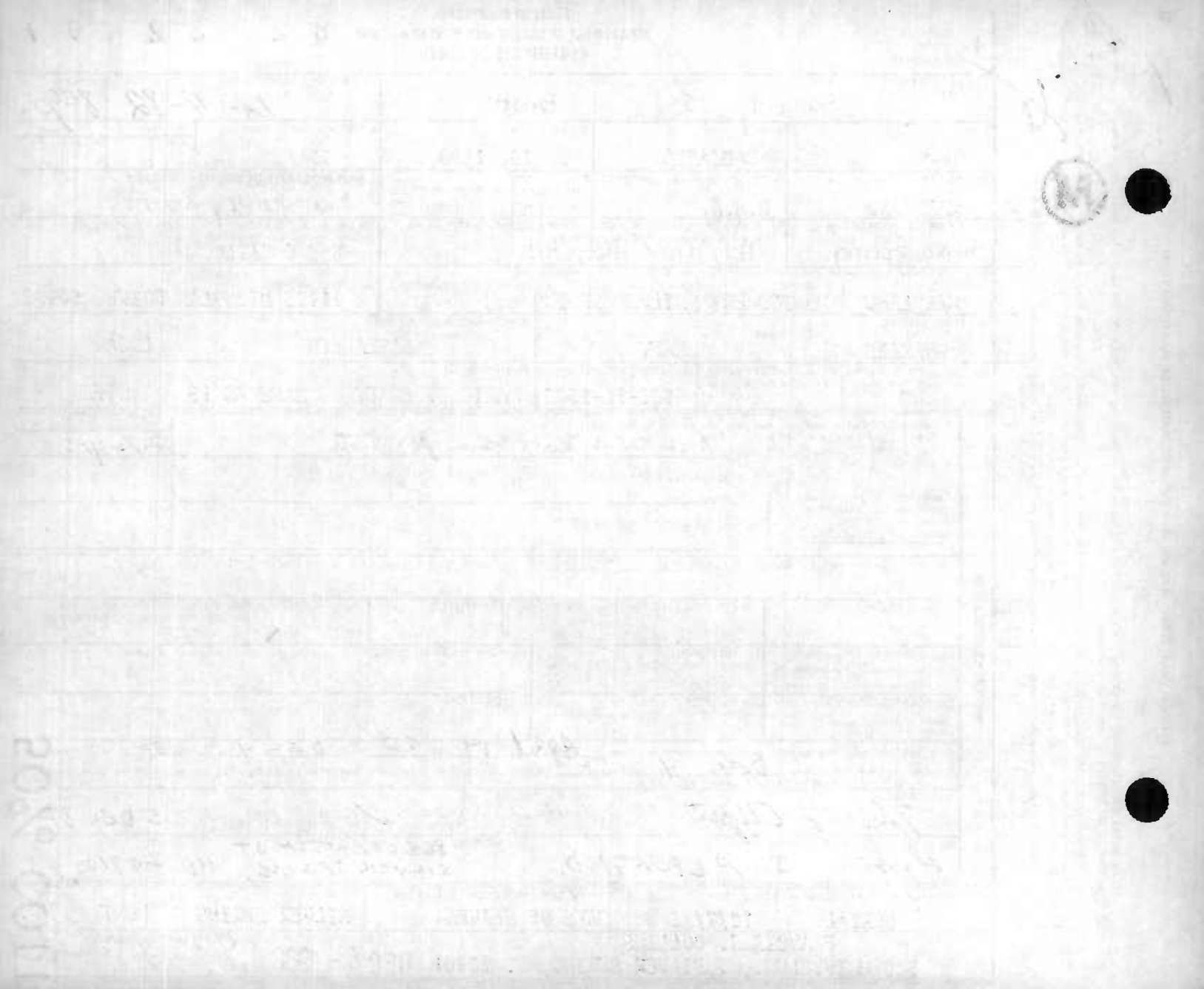
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 4 9 9

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		12 4 82		850 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
male		CAUCASIAN		NOV 19, 1905		77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				Montgomery County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital		B & O RAILROAD			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		11125 NICHOLAS DRIVE		20902	
CHARLES		BRATT		ELIZABETH		LOGAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
NO		705-12-3300		MARIE P. BRATT		SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Metastatic carcinoma prostate							2 1/2 yrs
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 17, 1980, to Dec 4, 1982, that (I) (we) lost saw the deceased alive on Dec 4, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Hubert J. Alpert		MD				5 DEC 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
HUBERT J. ALPERT, MD		8630 FENTON ST SILVER SPRING, MD 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		12/7/82		GATE OF HEAVEN		CITY OR TOWN COUNTY STATE	
						SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS		DEC 8 - 1982		John J. Cahill			
FRANCIS J. COLLINS							
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

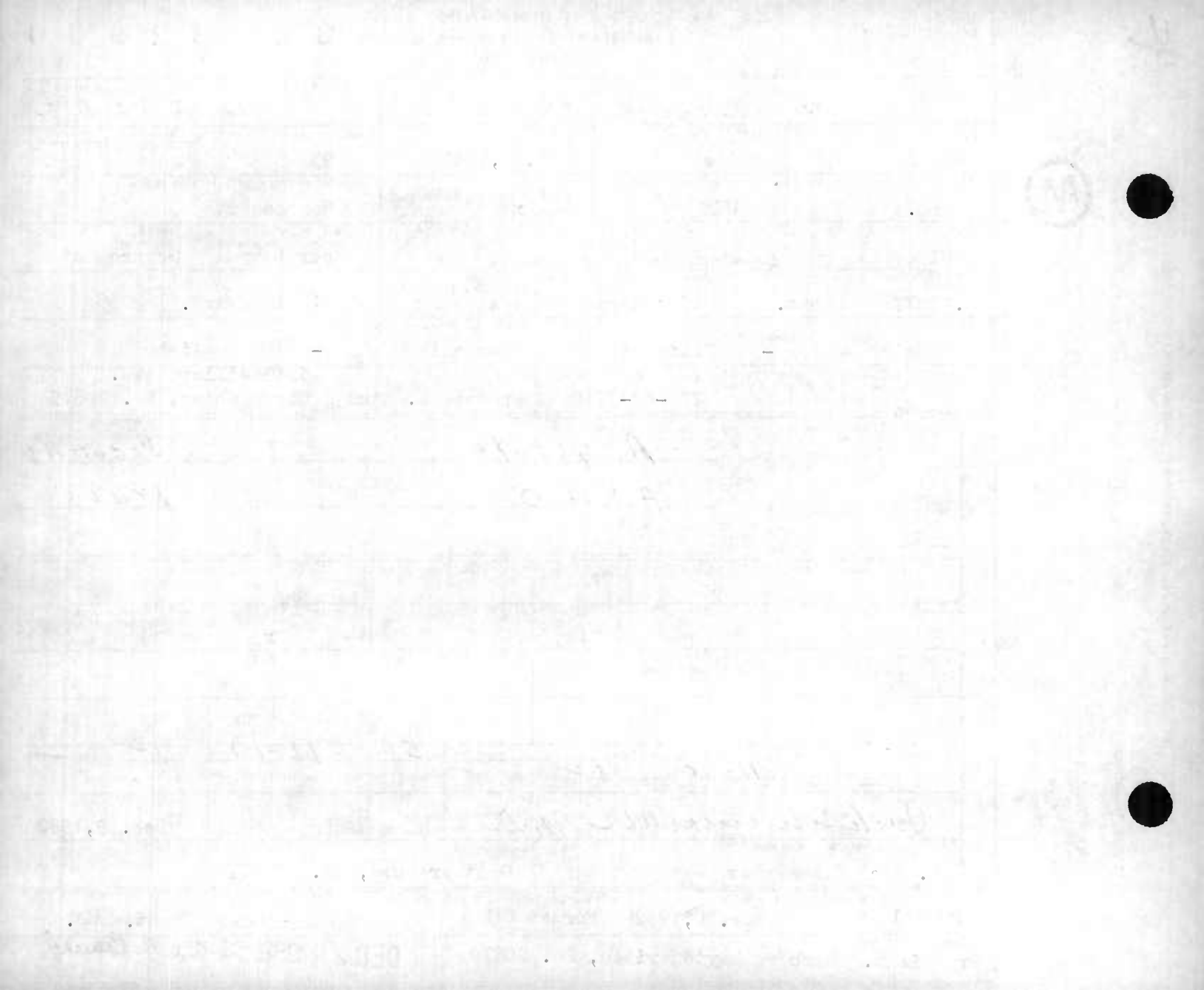
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) MAE ELIZABETH BRIGGS					2a. DATE OF DEATH MONTH 12 DAY 17 YEAR 82		2b. HOUR 11:05 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Sept. DAY 10 YEAR 1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NURSING				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5 Highland Ave.	
14. FATHER'S NAME FIRST Maurice MIDDLE - LAST Phoebe		15. MOTHER'S MAIDEN NAME FIRST Armenia MIDDLE - LAST English		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					
16a. SOCIAL SECURITY NO. 220-44-5710		17. INFORMANT Armenia B. Stup							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Asystole DUE TO, OR AS A CONSEQUENCE OF (b) A.S.I.D. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Seconds Years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-18 19 82 to 12-17 19 82 , that (I) (we) last saw the deceased alive on 11-18 19 82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jack Schumacher		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Dec. 19, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jack Schumacher		22e. ADDRESS Gaithersburg, Md. 20877							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Dec. 20, 1982		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION CITY OR TOWN Gaithersburg COUNTY Mont. STATE Md.			
24. FUNERAL DIRECTOR NAME Francis H. Barber		Laytonsville, Md. 20879		25a. DATE RECEIVED BY REGISTRAR DEC 22 1982		25b. REGISTRAR'S SIGNATURE John J. Smith			

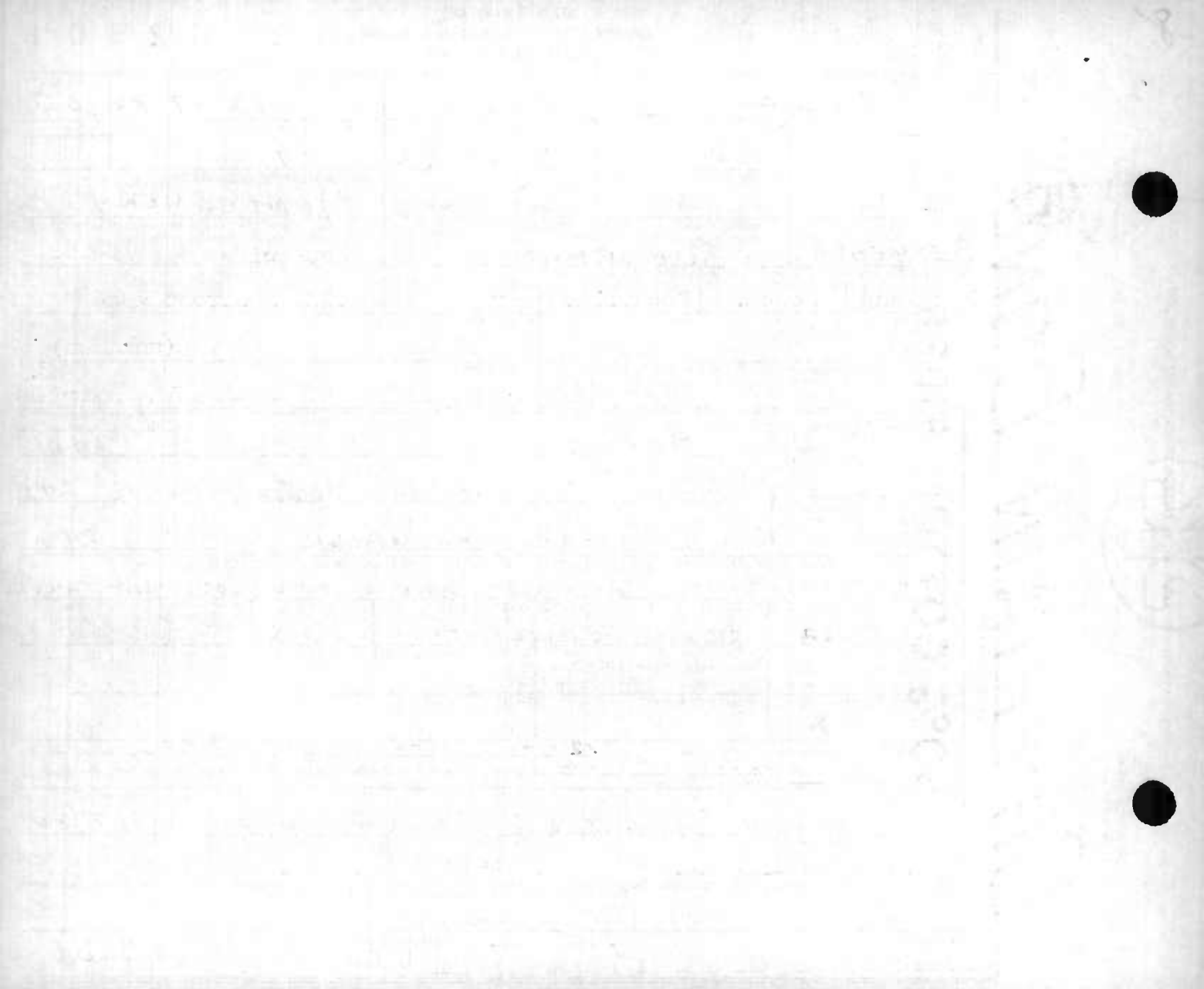


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified. **RELEASED BY MEDICAL EXAMINER**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 0 1 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CELIA C. BRILL				2a. DATE OF DEATH MONTH DAY YEAR 12 17 82		2b. HOUR MIN 10³⁵ PM	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12 25 92		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 6121 Montrose Road		14. FATHER'S NAME FIRST MIDDLE LAST Jacob Caster		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 182-28-8842B		17. INFORMANT ADDRESS Isidore Brill; 6121 Montrose Rd., Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS 5679 DUE TO, OR AS A CONSEQUENCE OF (b) RIGHT COLON AND SMALL BOWEL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) MESENTERIC THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 h 24 h 24 h
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE + CONGESTIVE FAILURE							
19a. DATE OF OPERATION 12/17/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE PERITONITIS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 82 , to 12/17 , 19 82 , that (I) (we) last saw the deceased alive on 12/17 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. Dr. Hanowell / [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/18/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. D. HANOWELL, M.D.				22e. ADDRESS 10401 Old Georgetown Road; Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-19-1982		23c. NAME OF CEMETERY OR CREMATORY Oheb Zedek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pottsville, Pa.	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR DEC 23 1982		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alice B. Buell</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>December 14 1982</i>			2b. HOUR MIN. <i>8:00 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 24 1892</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>90</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Illinois</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4750 Chevy Chase Dr.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. STREET ADDRESS <i>4750 Chevy Chase Drive</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles P. Burton</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cora Vreeland</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>328-07-3013</i>		17. INFORMANT ADDRESS <i>Charles Burton Rt. 3 Glen Eagles Dr. Lebanon, New Jersey</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

4292

IMMEDIATE CAUSE (a)

Cardiac arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

immediate

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *atherosclerotic cardio & cerebrovascular years*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

M. tral & aortic valvular disease. Uncoverated metastatic carcinoma

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>none</i> 19 <i>82</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>none</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>none</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>none</i>			
22a. I certify that (I) (the hospital) attended the deceased from <i>Dec 15</i> , 19 <i>82</i> , to <i>Dec 16</i> , 19 <i>82</i> ; that (I) (we) lost saw the deceased alive on <i>Dec 16</i> , 19 <i>82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Allen J. O'Neill</i>				DEGREE		22c. DATE SIGNED <i>12/14/1982</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Allen J. O'Neill</i>				22e. ADDRESS <i>8601 Old Georgetown Rd. Bethesda, Maryland</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b. DATE <i>12/14/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Geo. Wash. Med. School</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Columbia Mortuary Services, Inc. 225 Missouri Ave. NW Washington, D.C.</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 20 1982</i>			
				25b. REGISTRAR'S SIGNATURE <i>John S. Smith</i>			

1. 1950 Chevy Chase Dr. Bethesda, Md. 20814
2. 1950 Chevy Chase Dr. Bethesda, Md. 20814
3. 1950 Chevy Chase Dr. Bethesda, Md. 20814
4. 1950 Chevy Chase Dr. Bethesda, Md. 20814
5. 1950 Chevy Chase Dr. Bethesda, Md. 20814
6. 1950 Chevy Chase Dr. Bethesda, Md. 20814
7. 1950 Chevy Chase Dr. Bethesda, Md. 20814
8. 1950 Chevy Chase Dr. Bethesda, Md. 20814
9. 1950 Chevy Chase Dr. Bethesda, Md. 20814
10. 1950 Chevy Chase Dr. Bethesda, Md. 20814

1950-01-10
Charles E. Norton
Charlton Norton, 1950 Chevy Chase Dr. Bethesda, Md. 20814

1. 1950 Chevy Chase Dr. Bethesda, Md. 20814
2. 1950 Chevy Chase Dr. Bethesda, Md. 20814
3. 1950 Chevy Chase Dr. Bethesda, Md. 20814
4. 1950 Chevy Chase Dr. Bethesda, Md. 20814
5. 1950 Chevy Chase Dr. Bethesda, Md. 20814
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7. 1950 Chevy Chase Dr. Bethesda, Md. 20814
8. 1950 Chevy Chase Dr. Bethesda, Md. 20814
9. 1950 Chevy Chase Dr. Bethesda, Md. 20814
10. 1950 Chevy Chase Dr. Bethesda, Md. 20814

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 0 3

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) NELL E. Bugbee			2a. DATE OF DEATH MONTH 12 DAY 15 YEAR 82		2b. HOUR 2230 M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH 8 DAY 25 YEAR 01		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) N. Dakota		13b. CITY OR TOWN New Rockford	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 208 s. 5th St. 58358	
14. FATHER'S NAME FIRST Ad MIDDLE Taylor LAST Taylor		15. MOTHER'S MAIDEN NAME FIRST Loretta MIDDLE Unknown LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 501 32 0071		17. INFORMANT Loretta Stock, daughter ADDRESS 16604 Baerberwood Lane Rockville, Md. 20855	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months
DUE TO, OR AS A CONSEQUENCE OF (b) Probably from Breast Primary		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 12/13 , 19 82 , to 12/15 , 19 82 , that (I) (we) lost saw the deceased alive on 12/15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)			
22b. SIGNATURE Stephen Newman M.D.		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/16/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Newman, M.D.		22e. ADDRESS Galthersburg, Maryland	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 3, 1983	23c. NAME OF CEMETERY OR CREMATORY Prairie Home Cemetery	23d. LOCATION New Rockford, N.D. STATE
24. FUNERAL DIRECTOR NAME Ives Funeral Home 2847 Wilson Blvd Arlington, Va. 22201		25. DATE REC'D. BY REGISTRAR DEC 20 1982	



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IX

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Handwritten text, possibly a signature or date, located in the bottom center area.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 5 0 4			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST JACOB		MIDDLE		LAST BURAK		2b. DATE OF DEATH		MONTH December	DAY 18	YEAR 1982	2b. HOUR 1:30 M
3. SEX Male		4. RACE White		5. DATE OF BIRTH		MONTH December		DAY 25		YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TOUR GUIDE		12b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYEE			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7333 New Hampshire Avenue #415	
14. FATHER'S NAME FIRST ALEX		MIDDLE		LAST BURAK		15. MOTHER'S MAIDEN NAME FIRST IDA		MIDDLE		LAST GREENSPAN		ADDRESS Chevy Chase, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-14-7216		17. INFORMANT Charles Futrovsky		ADDRESS 8805 Montgomery Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction, acute DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1425 DAYS 104pm			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Nov , 19 82 , to 19 Dec , 19 82 , that (I) (we) lost saw the deceased alive on 18 Dec , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert T. Kelley, MD		DEGREE		22c. DATE SIGNED 19 Dec 82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. KELLEY, MD		22e. ADDRESS 8218 Wisconsin Ave Bethesda, Md											
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/20/82		23c. NAME OF CEMETERY OR CREMATORY EZRAS ISRAEL CEM		23d. LOCATION CITY OR TOWN COUNTY STATE Capitol Hgts; P.G.; Md.							
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG CHAPELS		ADDRESS 1170 Rockville Pike; Rockville, Md. 20852		25a. DATE REC'D BY REGISTRAR DEC 22 1982		25b. REGISTRAR'S SIGNATURE John J. Lohr							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 0 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marjorie Rebecca BURDETTE		2a. DATE OF DEATH MONTH DAY YEAR 12 27 82		2b. HOUR 7 ⁰⁰ A.M.	
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7 17 10	
6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2629 Kidge Rd Damascus			
14. FATHER'S NAME FIRST MIDDLE LAST Colvin Hughsie McElfresh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophronia Burdette			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-80-4067		17. INFORMANT Claude E. Burdette, Item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest 3208 DUE TO, OR AS A CONSEQUENCE OF (b) E. Coli Meningitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 12/10 1982, to 12/27 1982, that (1) (we) lost the deceased alive on 12/26 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Mark H. Elg		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK H. ELG		22e. ADDRESS 1801 Gayne Ave Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 29, 1982		23c. NAME OF CEMETERY OR CREMATORY Bethesda U. Meth.	
23d. LOCATION CITY OR TOWN COUNTY STATE Browningsville, Montg., Md.					
24. FUNERAL DIRECTOR NAME Clyde L. Molesworth, P.A., Damascus, Md.		25a. DATE REC'D. BY REGISTRAR DEC 30 1982		25b. REGISTRAR'S SIGNATURE John J. L... ..	

MEDICAL CERTIFICATION

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1- FOR
STATE
REGISTRAR

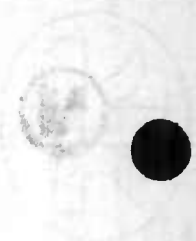
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 0 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) YVONNE C. BURGER			2a. DATE OF DEATH MONTH DAY YEAR 12/7/82		2b. HOUR 5:05A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 25, 1915	6. AGE (IN YEARS LAST BIRTHDAY) 67 YEARS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LOUISIANA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON AVENTIST HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY LEGAL SECTY.	
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SIL. SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 641 SLIGO AVENUE	
14. FATHER'S NAME FIRST MIDDLE LAST GOMEZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS STEWART P. BURGER (SAME AS #13 ABOVE)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST Conditions, if any, which gave rise to immediate cause (b) PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) 3 loop years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1): COPD, Obesity, Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12-5	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12-5 19 82 to 12-7 19 82 , that (I) (we) last saw the deceased alive on 12-6 19 82 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John L Ford (M.D.)		DEGREE MD			22c. DATE SIGNED 12-7-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN L FORD		22e. ADDRESS 344 University Blvd W Silver Spring MD 20901			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 10, 1982	23c. NAME OF CEMETERY OR CREMATORY Fort Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lynchburg Virginia	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, Silver Spring, Md		ADDRESS 2500 Carroll Lane, DC		25. DATE REC'D. BY REGISTRAR DEC 9 1982	
				REGISTRAR'S SIGNATURE John J. Carver	

BP



W. H. C. 1915
MONTGOMERY

WASHINGTON MONUMENT RETIRED
441 21st Avenue

Stewart J. Burger
Game Warden

Stewart J. Burger
Game Warden
Washington Monument
441 21st Avenue

Stewart J. Burger
Game Warden
Washington Monument
441 21st Avenue

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 5 0 7	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Della - Burk					2a. DATE OF DEATH MONTH DAY YEAR December 18, 1982			2b. HOUR 3:00 am			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR UNKNOWN		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H.wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md. 20900		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10120 N. Hampshire Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Robert - Garland					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie - Green						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-8980		17. INFORMANT ADDRESS Gary Sexton Silver Spring, Md. 20906							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rt. Lower Lobe pneumonia 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Chloroform - Atrial fibrillation								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 1 month years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: AZOTEMIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Nov. 17 , 19 82 , to Dec. 18 , 19 82 , that (I) (we) last saw the deceased alive on Dec. 18 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Cezar A. Lopez		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Dec-18, 1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CEZAR A. LOPEZ, M.D.		22e. ADDRESS 18111 Prince Philip Dr. OLNEY, MD.									
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL		23b. DATE DEC. 21, 1982		23c. NAME OF CEMETERY OR CREMATORY Seals Farm		23d. LOCATION CITY OR TOWN COUNTY STATE Etchison Mont. Md.					
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE John G. Carrier					

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BP

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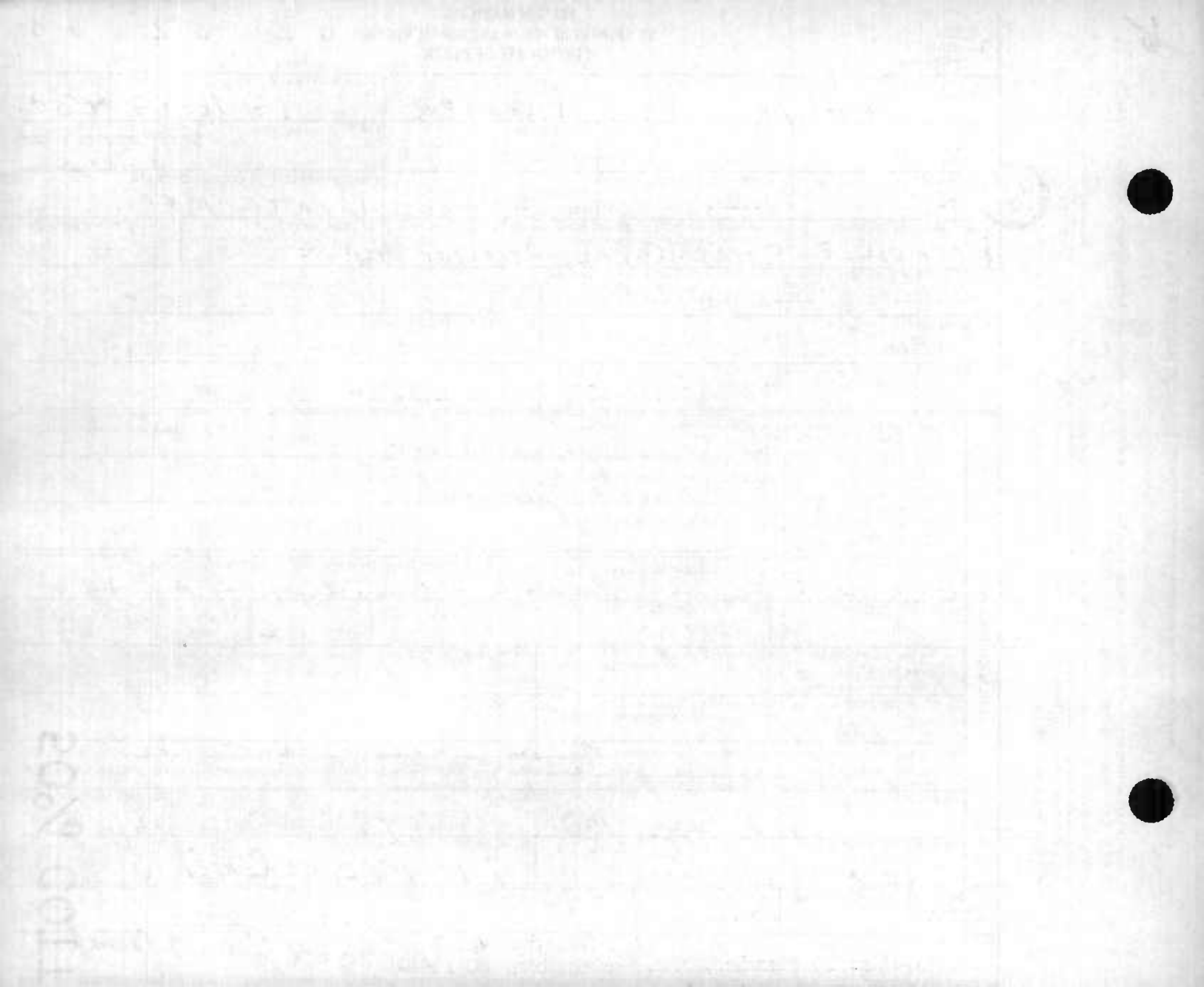
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MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 0 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>PHILOR J BUTLER</u>				2a. DATE OF DEATH MONTH <u>12</u> DAY <u>16</u> YEAR <u>82</u>				2b. HOUR <u>9:55 A.M.</u>			
3. SEX <u>Female</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH <u>November</u> DAY <u>17</u> YEAR <u>1899</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Georgia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.					
10. CITY OR TOWN OF DEATH <u>ROCKVILLE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SHADY GROVE ADVENTIST HOSP.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Dressmaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>Maryland</u>				13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Potomac</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>7824 Horseshoe Lane</u>	
14. FATHER'S NAME FIRST <u>Berrian</u> MIDDLE <u></u> LAST <u>Bell</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Grace</u> MIDDLE <u></u> LAST <u>(Information not available)</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>				16b. SOCIAL SECURITY NO. <u>381-30-0365</u>		17. INFORMANT ADDRESS <u>Robert Bell, son, same address</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4340</u> IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thromboses</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Acute Renal Failure - Pneumonia - Cardiac Respiratory Arrest</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-3-82</u> , 19 <u>82</u> , to <u>12-15</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12-15</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John E. Kelly MD</u>				DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-16-82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN E. KELLY</u>				22e. ADDRESS <u>9715 MEDICAL CENTER DR.</u>							
23a. BURIAL, CREMATION, REMOVAL <u>Removal</u>				23b. DATE <u>Dec. 21, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Detroit, Michigan</u>			
24. FUNERAL DIRECTOR NAME <u>McGuire Funeral Service, Inc.</u>				4740 Georgia Ave. NW ADDRESS Washington, DC		DATE REC'D. BY REGISTRAR <u>DEC 23 1982</u> <u>John E. Kelly</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMM - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 5 0 9			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR			
FIR Sheba MIDDLE B. LAST Caplan Sheba CAPLAN				12 12 82 7 ³⁰ P.M.			
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 11, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS				13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS				13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST Jacob - Levy				15. MOTHER'S MAIDEN NAME MIDDLE LAST Lilly - Panitz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-22-3026		17. INFORMANT ADDRESS Marlyn Cohen-4200 Mass.Ave., N.W.-Wash., D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MARCH 19 82 to DEC 12 19 82, that (I) (we) lost saw the deceased alive on DEC 9 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE Francis Chucker MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-12-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS CHUCKER MD				22e. ADDRESS 2700 CALVERT ST NW WASH DC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/82		23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W.-Washington, D.C.				25. DATE RECEIVED BY REGISTRAR REGISTRAR'S SIGNATURE DEC 20 1982 John J. Smith			

MEDICAL CERTIFICATION

1. The first group of people who are not in the military are the people who are in the military but are not in the military.

1. $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 1 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Mieko Imagi Caudill</i>				2a. DATE OF DEATH MONTH DAY YEAR 12 25 82			
3. SEX female				4. RACE 5 Oriental		5. DATE OF BIRTH MONTH DAY YEAR 9 14 23	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Japan		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7c. HOUR 3:53 P M	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Science Analyst	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST Sellchiro Imagi				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shizuko Imagi			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 023-30-8357		17. INFORMANT ADDRESS Charlotte H. Caudill same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for cause (a) and (b). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac resp. Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial Infarction</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his) (her) attended the deceased from 19 78 to 19 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Carol L. Bender</i> DEGREE				22c. DATE SIGNED 12/25/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carol L. Bender	
22e. ADDRESS 11125 Rockville Pike Rockville, Md. 20852				22f. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 12/27/82		23c. LOCATION Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Maryland 20852				25. DEC 30 1982			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

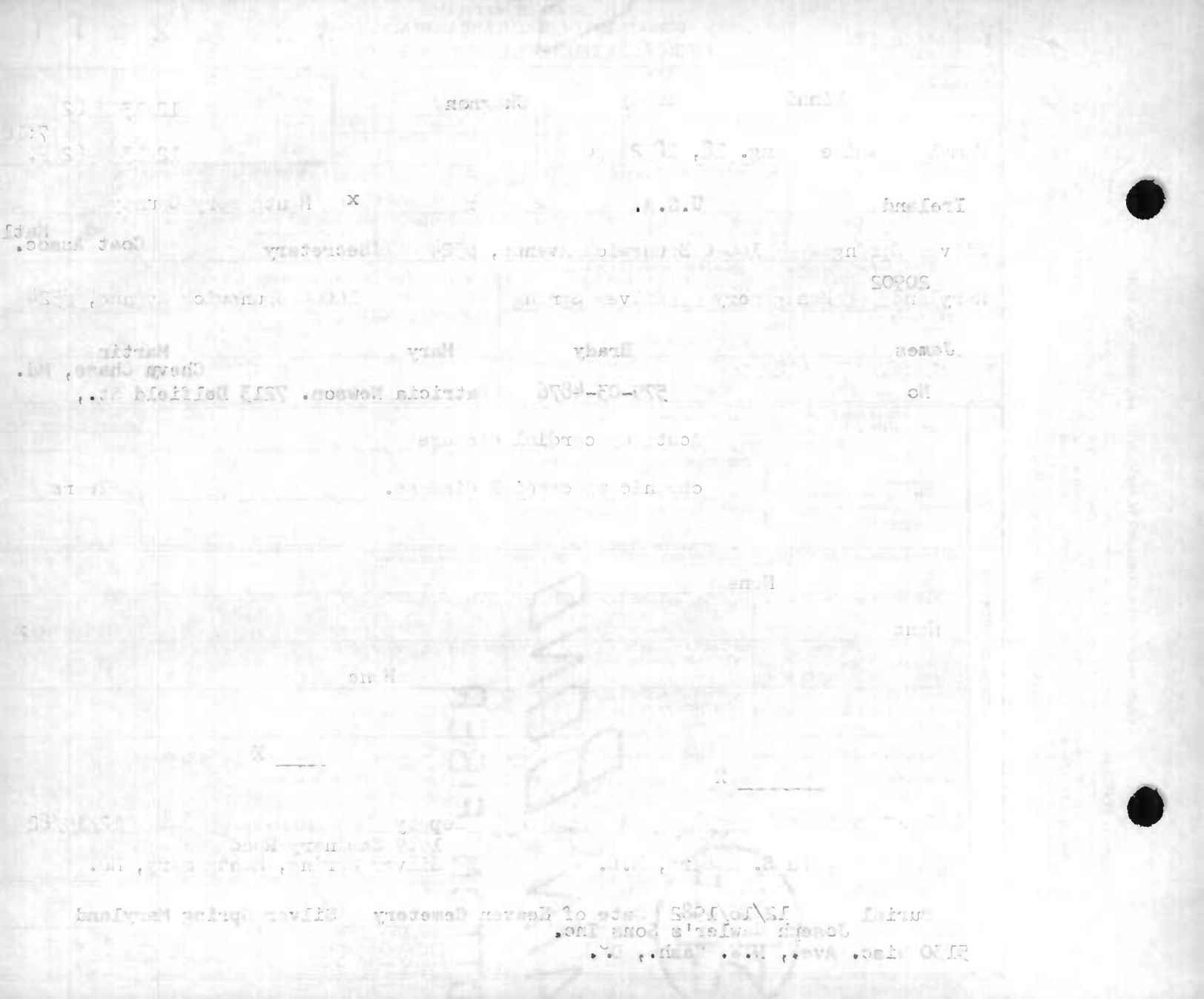
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Minnie		MIDDLE Brady		LAST Chagnon		2a. DATE KNOWN OF DEATH		MONTH 12/13		DAY 19		YEAR 82		2b. HOUR 7:10 P. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 18, 1892		6. AGE (IN YEARS) (LAST BIRTHDAY) 90 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12/13 19 82		7d. HOUR P. M.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Nat'l Coat Assoc.									
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10000 Brunswick Avenue, #524		12c. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10000 Brunswick Avenue, #524					
14. FATHER'S NAME FIRST MIDDLE LAST James Brady		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Martin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-03-4876		17. INFORMANT Patricia Newson. 7213 Delfield St.,		ADDRESS Chevy Chase, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) <u>chronic myocardial disease.</u> (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None																	
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE John S. Rogers, M.D.				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 12/14/82									
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/16/1982				23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland					
24. FUNERAL DIRECTOR 5130 Wisc. Ave., N.W. Ash., D.C.				25a. DATE REC'D. BY REGISTRAR DEC 20 1982				25b. REGISTRAR'S SIGNATURE John J. Connelley									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 2 5 1 2	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) EARL C. Chamberlayne								2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 3 1982 2b. HOUR 6:45 P M	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 2 7 1966	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 12 - 3 - 82	19		2d. HOUR 4:45 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) VETERINARIAN		12b. KIND OF BUSINESS OR INDUSTRY N.I.H., USG			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4709 Fernwood Rd			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Chamberlayne				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise unk							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. None		17. INFORMANT Marion Chamberlayne		ADDRESS see 13E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8169 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Multiple injuries, severe DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Seizure Disorder											
19a. DATE OF OPERATION 12-3-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Multiple INTRATHORACIC INJURIES						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:45 P.M. 12 3 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) LOST CONTROL of car AND HIT tree							
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) NIH		21f. LOCATION STREET CITY OR TOWN COUNTY STATE NIH Bethesda MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tauber		TITLE (SPECIFY) _____				M.D. _____		MEDICAL EXAMINER		DATE SIGNED 12-3-82	
EXAMINER'S NAME (TYPE OR PRINT) John Tauber		ADDRESS 8218 Wisconsin Ave.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-6-82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md				
24. FUNERAL DIRECTOR NAME W.H. Chambers Co ADDRESS 8635 Georgia St				25a. DATE REC'D. BY REGISTRAR DEC 9 1982		25b. REGISTRAR'S SIGNATURE John Tauber					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 5 1 3	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Agnes m Chaney						2a. DATE OF DEATH MONTH DAY YEAR 12-31 Dec 31 82			2b. HOUR 6:30 M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 5 1891		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brook Grove Foundation				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. U.S. Gov. Worker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.						13b. CITY OR TOWN Pr. Geo.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3817-40th Ave. (20722)	
14. FATHER'S NAME FIRST MIDDLE LAST William Green						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Buchanan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577-38-7260		17. INFORMANT ADDRESS 16601- New Hampshire Ave., Silver Sp., Md.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) CVA Rt Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: Chronic S.V. Disease DUE TO, OR AS A CONSEQUENCE OF (c) 2 wks years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Stomach Calculus Left Kidney											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/29 to 12/31 , 19 82 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE [Signature]				DEGREE				22c. DATE SIGNED 12/31/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. [Signature]				22e. ADDRESS 1811 P+ Philip St, Olney Md 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/4/1983		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION STREET CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME Valley's F.H. Inc.				ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR JAN 4 1983		25b. REGISTRAR'S SIGNATURE [Signature]			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 5 1 4			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
CHARALAMBOUS CHARALAMBOS				DECEMBER 7, 1982			
3. SEX				6. AGE (IN YEARS LAST BIRTHDAY)			
MALE				8			
4. RACE				5. DATE OF BIRTH			
WHITE				AUGUST 9, 1974			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
CYPRUS				CYPRUS			
10. CITY OR TOWN OF DEATH				9. BALTIMORE CITY OR COUNTY OF DEATH			
BETHESDA				MONTGOMERY COUNTY MD.			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
NIH, CLINICAL CENTER				student			
13a. STATE				13b. INSIDE CITY LIMITS?			
CYPRUS				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
GREGORY CHARALAMBOS				EMILY NICOLAOU			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
no				n/a			
17. INFORMANT				ADDRESS			
Mrs. EMILY CHARALAMBOS (MOTHER)				SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
7473 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) DUE TO, OR AS A CONSEQUENCE OF CONGENITAL HEART DISEASE			
				(c) DUE TO, OR AS A CONSEQUENCE OF S/P EXPLORATION-NONCORRECTABLE LESION			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
NONCORRECTABLE PULMONARY ATRESIA							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
DECEMBER 1, 1982							
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 27, 1982, to December 7, 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 7, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE				22c. DATES SIGNED			
Robert D. Moses, M.D.				12/7/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
ROBERT D. MOSES				NIH, CLINICAL CENTER, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
BURIAL				12/13/82			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
St. Georges Church Cem				LATSIA, NICOSIA, CYPRUS			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
Marshall's Funeral Home				25b. REGISTRAR'S SIGNATURE			
4217 9th St NW, Washington, D.C.				DEC 16 1982			

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NOTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 1 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) REBECCA N CHINN			2a. DATE OF DEATH MONTH DAY YEAR 12-25-82			2b. HOUR 9:13A M								
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08-22-04		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD								
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT, IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian		12b. KIND OF BUSINESS OR INDUSTRY Mont. Co.						
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6017 Kirby Rd. Zip: 20817					
14. FATHER'S NAME FIRST MIDDLE LAST Dr. Upton D. Nourse				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Windsor										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-32-1018		17. INFORMANT ADDRESS Jane C. Sween, Daughter, Same as item #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: 4019 IMMEDIATE CAUSE (a) Cardio-Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years 11									PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from July 19, 1947 to 12/25/82 , that (I) (we) lost saw the deceased alive on 12/24/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22b. SIGNATURE Thos B. Ward DEGREE MD			22c. DATE SIGNED 12/25/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos B. Ward			22e. ADDRESS 6116 Robinwood, Bethesda, Md 20817			22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 29, 1982		23c. NAME OF CEMETERY OR CREMATORY Darnestown Presbyterian Church Cem. Darnestown, Maryland			23d. LOCATION CITY OR TOWN COUNTY STATE						
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey			24b. ADDRESS Funeral Homes, P.A., Rockville, Maryland			25. DATE RECEIVED BY REGISTRAR JAN 5 1983			25b. REGISTRAR'S SIGNATURE [Signature]					

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Handwritten text at the bottom left corner, possibly a signature or date: "Handwritten text" and "1881".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Louis Chipouras			2a. DATE OF DEATH MONTH DAY YEAR 11-29-82			2b. HOUR 6 ³⁰ M			
3. SEX male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3-13-27		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Representative		12b. KIND OF BUSINESS OR INDUSTRY Foods	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2212 Coleridge Drive 20910	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Chipouras				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antonia Vlahos					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT Louis Chipouras-son - (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 7991 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sleep Apnea Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>10</u> 19 <u>81</u> to <u>11/29</u> 19 <u>82</u> , that (I) (we) lost above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Jay Weiner MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner MD						22e. ADDRESS 4701 Randolph Rd Rockville, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-2-1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home			11800 N.H. Avenue, ADDRESS Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR DEC 1 - 1982		25b. REGISTRAR'S SIGNATURE John J. Conner		

BP

11500 N. 1st Avenue
 Silver Spring, Md.
 Date of Death 12-3-1983
 Silver Spring, Md.
 11500 N. 1st Avenue
 Silver Spring, Md.

Yes 11-11 258-30-0157 Linda Chipman - (same as the)

Linda Chipman Antioch Virginia

Linda West County Silver Spring 258-30-0157

Linda West County Silver Spring 258-30-0157

Linda

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Stanwood Cobb			2a. DATE OF DEATH MONTH DAY YEAR December 29, 1982			2b. HOUR 3:40p. M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 6, 1881		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19 Grafton Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Educator		12b. KIND OF BUSINESS OR INDUSTRY Schools		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 20815			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 19 Grafton Street	
14. FATHER'S NAME FIRST MIDDLE LAST Darius -- Cobb			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura -- Lillie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-34-2475		17. INFORMANT ADDRESS Scott Hough, Same address as #13.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4409 Congestive Heart Failure IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year. 50 years.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 24 Dec 1982 , 19 82 , to Dec , 19 82 , that (I) (we) lost saw the deceased alive on 24 Dec 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE David R. Lawrenz			DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/29/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David R. Lawrenz			22e. ADDRESS 1145 19th St. N.W., Washington, D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/3/83		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016										

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附註：(1) 此項研究係由「行政院客家委員會」補助，特此聲明。

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Rock Creek Cemetery

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, IMMEDIATELY AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21 32519	
1. DECEASED NAME (TYPE OR PRINT) Michael S. Coble							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 12 24 82		2b. HOUR 6:00 AM		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH 11 DAY 9 YEAR 62		6. AGE (IN YEARS LAST BIRTHDAY) 20 RS.		7. DATE PRONOUNCED DEAD MONTH 12 DAY 24 YEAR 82		7b. HOUR 6:00 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery City MD.			
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1705 McAuliffe Drive	
14. FATHER'S NAME FIRST Joseph MIDDLE Edward LAST Coble						15. MOTHER'S MAIDEN NAME FIRST Barbara MIDDLE DiPietro LAST DiPietro					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214 80 3822		17. INFORMANT ADDRESS Diane H. Coble same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries Severe 8147 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 12:00 P.M. MONTH 12 DAY 12 YEAR 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Struck By automobile					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET I 495 CITY OR TOWN River Rd COUNTY Montgomery STATE Bethesda Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John T. Tauber						TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED 12-24-82	
EXAMINER'S NAME (TYPE OR PRINT) John T. Tauber						ADDRESS 8218 WISCONSIN AVE.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/28/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d. LOCATION CITY OR TOWN Silver Spring COUNTY Maryland STATE Md			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR DEC 30 1982		25b. REGISTRAR'S SIGNATURE John J. Connel			

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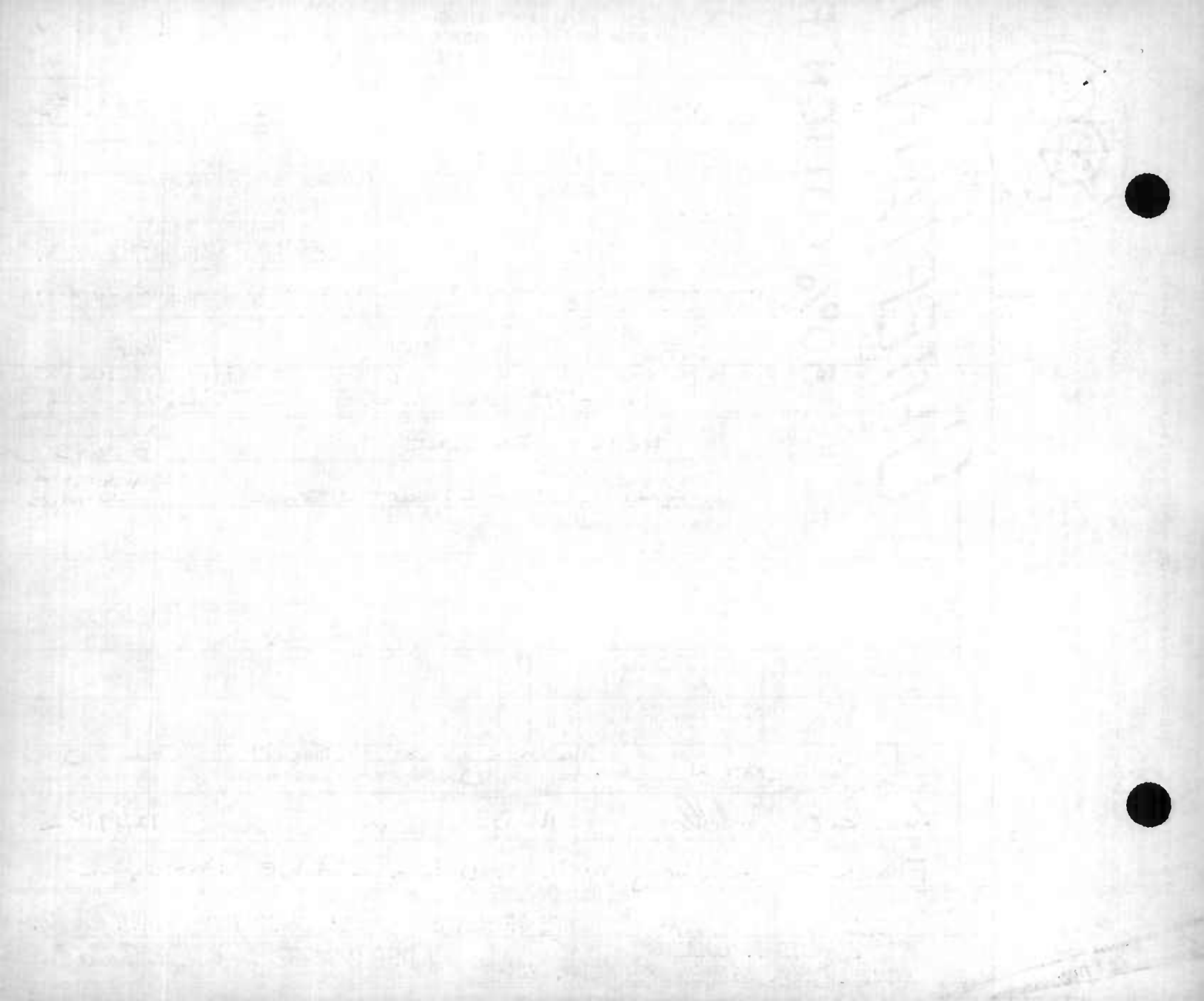
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 3 2 5 2 0			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 12-17-82			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANN MARY COFFEY				7b. HOUR 2 ⁴⁵ P.M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV 21, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH CHEVY CHASE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHEVY CHASE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY NAT'L RIFLE ASSN.	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL COFFEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KINNEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 474-10-4572		17. INFORMANT ATTORNEY EDWARD L. CAREY		ADDRESS 11108 ARDWICK DRIVE ROCKVILLE, MD. 20852	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days greater than 20 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 19 81, to Dec. 17, 19 82, that (II) (we) lost saw the deceased alive on Nov. 21, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE Frank E. Goldberg M.D.				DEGREE M.D.		22c. DATE SIGNED 12/17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank E. Goldberg, M.D.				22e. ADDRESS 1140 Varnum St. NE, Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/22/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR'S NAME FRANCIS J. COLLINS				25. DATE REC'D. BY REGISTRAR DEC 27 1982			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				REGISTRAR'S SIGNATURE John J. Gairish			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		HUGO CONEY		DEC 21, 1982		3:42 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
male		white		MONTH DAY YEAR SEPT. 13 1903		79 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
GERMANY		U. S. A.				MONTGOMERY COUNTY MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
SILVER SPRING		HOLY CROSS HOSPITAL							
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
MANAGEMENT		FOOD							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		MONTGOMERY		WHEATON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4238 ISBELL ST.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST MEYER COHN		FIRST MIDDLE LAST IDA ISRAEL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		579-16-2657		RICHARD FETTERS, 4238 ISBELL STREET WHEATON, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute and Chronic Gastrointestinal blood loss</i> 5789 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Maturity Onset Diabetes mellitus, Atherosclerotic Heart Disease, Chronic Indwelling Foley Catheter</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>12-21</i> , 19 <i>82</i> , to <i>12-21</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>12-21</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Phillip W. Poth</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED DEC. 21, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Phillip W. Poth, MD</i>		22e. ADDRESS <i>818 18th STREET, N. W. WASHINGTON, D. C.</i>							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/22/1982		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY ADELPHI, PRINCE GEORGES, MARYLAND			
24. FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		24b. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR DEC 27 1982					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH A. CONLON			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12 DAY 19 YEAR 82			2b. HOUR 7a M		
3. SEX female	4. RACE White	5. DATE OF BIRTH MONTH 1 DAY 9 YEAR 14	6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD 12/19/82 7a M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Class. Specialist		12b. KIND OF BUSINESS OR INDUSTRY FBI U.S. Gov't.
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE 20816 Md.		13b. CITY Mont.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5606 Newington Road
14. FATHER'S NAME FIRST Charles MIDDLE J. LAST Conlon, Sr.			15. MOTHER'S MAIDEN NAME FIRST Rosemary MIDDLE Meade LAST Meade					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-60-0813		17. INFORMANT ADDRESS Margaret Conlon, Same as item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 5789 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Gastro intestinal DUE TO, OR AS A CONSEQUENCE OF (c) Idem morbo								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John Tauber			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER 8218 Wisconsin Ave		
EXAMINER'S NAME (TYPE OR PRINT) John Tauber			ADDRESS 8218 Wisconsin Ave					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/21/1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN Silver Spring, Maryland COUNTY STATE	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.					25a. DATE REC'D. BY REGISTRAR DEC 29 1982 BY REGISTRAR John J. [Signature]			

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Class. Specialist U.S. Gov't

5005 Newington Road

Bedford

5005 Mt. View

Home

Remedy

Conlon, Dr.

U.

Charles

Harriet Conlon, age 45

77-60-0013

No

Handwritten notes:
Conlon, Dr.
Harriet Conlon

12/1/1955 Date of Heaven Cemetery Silver Spring, Maryland.
Joseph Lawler's Sons Inc.
2750 Ave. N.W., Wash., D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
Christopher KEVIN Cook						XX			12 8 1982			8:02 a. M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		White		7-24-1955		27 YRS.		4 14				12 8 1982		8:02 a. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Penna.				U.S.A.								Montgomery County, MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Rockville				Shady Grove Hospital				Student							
13a. STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS			
Md. 21776				Frederick New Windsor				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				15132 New Windsor Rd.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST				FIRST MIDDLE LAST											
Leslie R. Cook				Jean E. Deuschle											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
(YES, NO, OR UNKNOWN)				(IF YES, GIVE WAR OR DATES)				219-66-3186				Brenda K. Cook, Same As #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1 DEATH WAS CAUSED BY:															
8121 IMMEDIATE CAUSE (a) Decapitation															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY?															
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
5:25 PM 12 8 1982				passenger in auto/tractor/trailer impact											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				road				Rt. 270 north of Rt. 124, Gaithersburg, Montgomery Co., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Dennis F. Smyth, M.D.				M.D. Assistant				12-9-82							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Dennis F. Smyth, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY							
Burial				12-11-1982				Mt. Olivet							
23d. LOCATION				COUNTY				STATE							
Frederick,								Md.							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Charles W. Burrier, Jr., Sykesville, Md.				DEC 13 1982				John J. Calver							

RECEIVED
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.



TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

RECEIVED



RECEIVED
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.

RECEIVED
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH COPIES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edmund Thomas Cook			2a. DATE KNOWN OF DEATH Dec 3 1982		2b. HOUR 11:00
3. SEX Male	4. RACE White	5. DATE OF BIRTH Aug 31 1926	6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD Dec 3 1982
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery County Fireman		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D.C.	
11a. STATE MD		11b. COUNTY Montgomery		11c. CITY OR TOWN Roseville	
14. FATHER'S NAME FIRST MIDDLE LAST George Milton Kemp Cook		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lititia Saucer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 576-26-7976		17. INFORMANT Ethel M. Cook ADDRESS Wife Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) 4291 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE John J. Collins		TITLE (SPECIFY) M.D. Dep.		DATE SIGNED Dec 3, 1982	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 7, 1982		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Veterans Cem.	
24. FUNERAL DIRECTOR NAME Francis J. Collins		23d. LOCATION CITY OR TOWN Cheltenham		23e. COUNTY Pr. Geo.	
23f. STATE Maryland		23g. DATE REC'D. BY REGISTRAR DEC 8 - 1982		23h. REGISTRAR'S SIGNATURE John J. Collins	

500 University Blvd., W. Silver Spring, Md.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 2 5

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Eunice V. Coronado			2a. DATE OF DEATH MONTH DAY YEAR Dec. 2, 1982			2b. HOUR 1:20 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 24 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 20016 D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4226 Brandywine St., N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel R Moore				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 092-16-8219		17. INFORMANT ADDRESS Helen Cramer, Sister. Same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic obstructive Pulmonary Dis. DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 min year 6 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from Nov 19 80 to Dec 2 1982 , that (I) (we) last saw the deceased living on Dec 2 1982 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (I have did not view the body after death.)									
22b. SIGNATURE Wm F LUKETT MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 12-2-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm F LUKETT				22e. ADDRESS 5000 Reno Rd NW Wash., D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/6/1982		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland			
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR DEC 6 - 1982		25b. REGISTRAR'S SIGNATURE John J. Gawler			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Dec. 5, 1985

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) COSTOS EVANGELOS COSTANTINOU			2a. DATE KNOWN OF DEATH ESTIMATED Dec 31 1982			2b. HOUR 5:30		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH Oct DAY 27 YEAR 11	6. AGE (IN YEARS) LAST BIRTHDAY 71 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD Dec. 31 1982		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH S. I. Spg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9705 Fairway Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY Mont. CITY OR TOWN S. I. Spg		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 9705 Fairway Ave				
14. FATHER'S NAME FIRST Evangelos MIDDLE LAST Costantinou			15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE LAST Alexander					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW11 577-12-4030		17. INFORMANT ADDRESS 5416 N. 100th Plaza Omaha, Nebr. 68134				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Chronic Myocardial Dis. (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER		DATE SIGNED Jan 1 1983		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME		ADDRESS 1905 Seminary Rd., S.S. Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-4-1983		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN Washington, DC COUNTY STATE		
24. FUNERAL DIRECTOR ADDRESS Hines/ Rinaldi Funeral Home 11800 N.H. Ave., S.S. Md. 20904				25a. DATE REC'D. BY REGISTRAR JAN 6 1983		25b. REGISTRAR'S SIGNATURE John S. Rogers		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 2 7

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Helma Mary Craver</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Dec. 22, 1982</i>			2b. HOUR <i>8:23 A.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 2, 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Tennessee</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.	
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>TAKOMA PARK</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>DANIEL SULLIVAN</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			
17. INFORMANT ADDRESS <i>5717 KENNEBUNK TERR. COLLEGE PARK MD.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4275 Cardiorespiratory arrest</i> IMMEDIATE CAUSE (a) <i>4275</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Acute Renal Failure Cognitive Inst Failure Seizures Disorder</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/19/82</i> to <i>12/22/82</i> , that (I) (we) lost saw the deceased alive on <i>12/21</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Antonio G. Uy m.d.</i>		22c. DATE SIGNED <i>12/22/82</i>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ANTONIO G. Uy m.d.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>12/27/1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MARYLAND NAT'L MEM'L</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>LAUREL TR. GEO. MD.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>John G. Walters 254 Carroll St. N.W. DC.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 27 1982</i>					

Transcript N. 8. A
✓
May 2, 1951

61
MONTGOMERY

James Earl Ray (phonetic)

Montgomery, Tennessee ✓
300 Holly Avenue

James Sullivan Mary

42-22-117 Mary M. Grever
Sullivan Grever
Cottage 1044 N. 1st
St. Petersburg, Fla.

11-17-51

James Earl Ray (phonetic)
Montgomery, Tennessee
300 Holly Avenue

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 5 2 8	
1. DECEASED NAME (TYPE OR PRINT) Glover RAY Crawford										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12 DAY 7 YEAR 1982	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 9 DAY 27 YEAR 49		6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.		IF UNDER 1 YR. MONTHS _____ DAYS _____		2b. HOUR 10:21 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nash Co. NC.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MONTH 12 DAY 7 YEAR 1982					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING TIME) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY Private			
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.											
13a. STATE 15 years										13b. CITY OR TOWN Montgomery	
13c. STREET ADDRESS Silver Spring										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Cleveland MIDDLE _____ LAST CRAWFORD										15. MOTHER'S MAIDEN NAME FIRST FLORA MIDDLE T LAST Belcher	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO. 238-86 8884	
17. INFORMANT'S NAME Barbara Fori ADDRESS 6731 N.H. Ave											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8199 Severe INTRA CRANIAL IMMEDIATE CAUSE (a) Severe INTRA CRANIAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) injury. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 342 AM MONTH 12 DAY 7 YEAR 1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) auto accident			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION CITY OR TOWN Bethesda COUNTY Montgomery STATE MD East west Highway			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tauber M.D.				TITLE (SPECIFY) _____				DATE SIGNED 12-7-82			
EXAMINER'S NAME (TYPE OR PRINT) John Tauber				ADDRESS 8218 Wisconsin Ave.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 11, 1982		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial			23d. LOCATION CITY OR TOWN Suitland COUNTY P.G. STATE Maryland		
24. FUNERAL DIRECTOR NAME R.N. Horton Co Morticians ADDRESS 600-Kennedy St. N.W.						25a. DATE REC'D. BY REGISTRAR DEC 14 1982			25b. REGISTRAR'S SIGNATURE John J. Canfield		



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Handwritten text, mostly illegible. Some words like "I" and "am" are faintly visible.

Handwritten text at the bottom of the page, mostly illegible. Some words like "I" and "am" are faintly visible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 2 9 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
3. SEX				5. DATE OF BIRTH MONTH DAY YEAR			
4. RACE				6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE				13b. COUNTY			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.			
17. INFORMANT ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 cardiovascular collapse				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) metastatic disease -							
DUE TO, OR AS A CONSEQUENCE OF (c) carcinoma of breast - primary							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/09 1982 to 12/23 1982, that (I) (we) lost saw the deceased alive on 12/22 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph M. Polius MD				22c. DATE SIGNED 12/23/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME John T. Stewart				25a. DATE REC'D. BY REGISTRAR 3 1983			
25b. REGISTRAR'S SIGNATURE John J. Carver							

BP _____

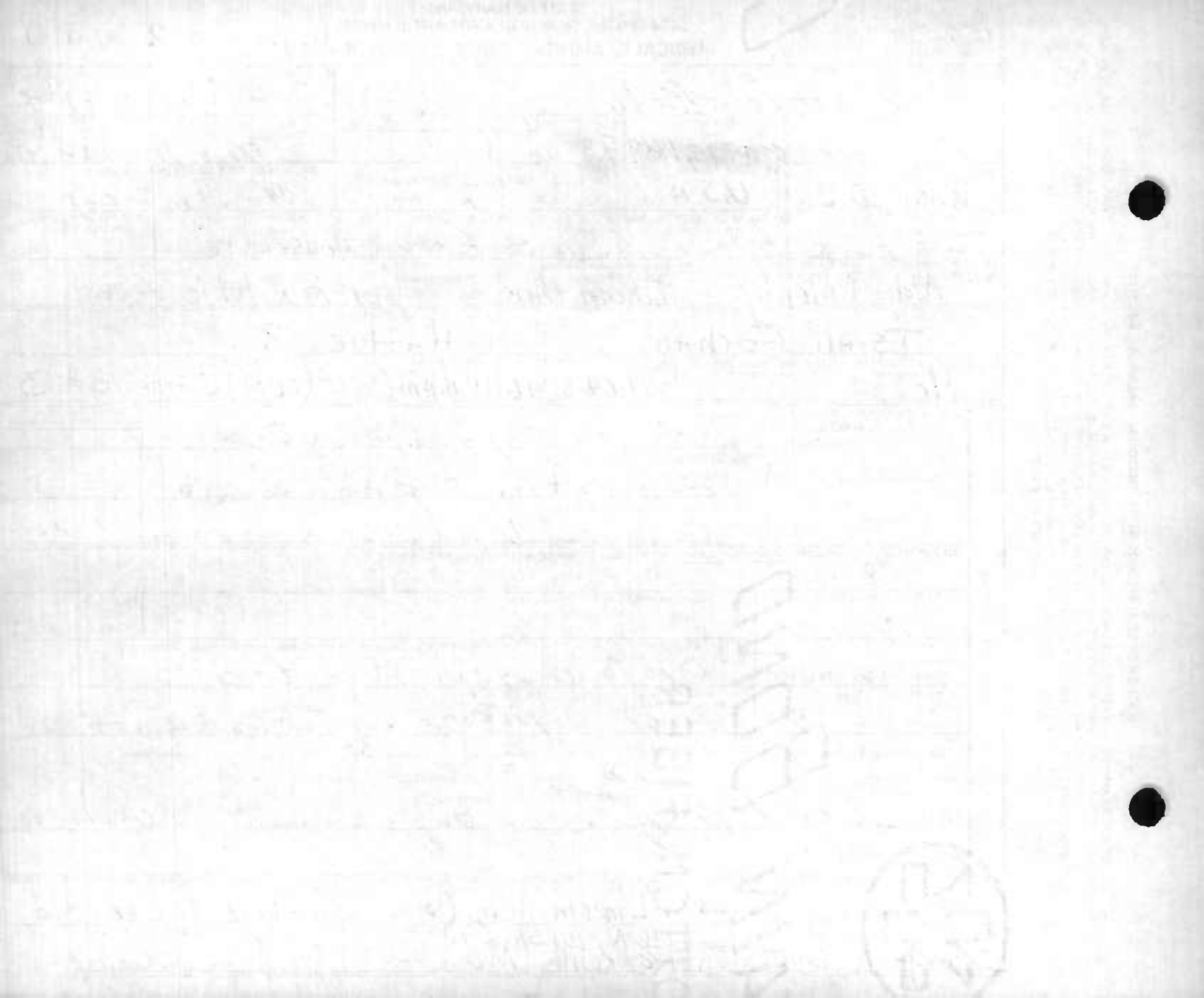
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 3 2 5 3 0	
1. DECEASED NAME (TYPE OR PRINT) Hattie Belle Cross										2a. DATE KNOWN OF DEATH Dec 11 1982	
3. SEX F	4. RACE WASH, D.C.	5. DATE OF BIRTH MAR 15 1889	6. AGE (IN YEARS) 93	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Dec 11 1982		2b. HOUR 6:20 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Tak Park Wash.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Advent. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 130 Ritchie Ave.			
14. FATHER'S NAME FIRST Isiah MIDDLE Gorham LAST				15. MOTHER'S MAIDEN NAME FIRST Hattie MIDDLE ? LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577-09-8346		17. INFORMANT ADDRESS William Cross (SON) SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Disi DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 9110 (b) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Vascular Accident 1 wk										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 1210 AM MONTH DAY YEAR 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Aspirated food					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET Ritchie Ave CITY OR TOWN Tak Park COUNTY Mont STATE MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature] M.D. Dep				TITLE (SPECIFY) Dep MEDICAL EXAMINER				DATE SIGNED Dec 11, 1982			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12-16-82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cem.		23d. LOCATION CITY OR TOWN Surtland Pr. Geo. COUNTY Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden ADDRESS 246 N. WASH. ST. Rockville, MD.				25a. DATE REC'D. BY REGISTRAR DEC 17 1982		25b. REGISTRAR'S SIGNATURE [Signature]					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 4 FOR 100 YEARS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										8 2 3 2 5 3 1 REG. NO.		
1- FOR STATE REGISTRAR 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Theodore Roosevelt Crutchfield</i>							2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>Dec 27, 1982</i>		2b. HOUR MIN <i>12 30 PM</i>			
3 SEX <i>M</i>		4 RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb 14, 1954</i>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>28</i>		IF UNDER 1 YR. MONTHS DAYS <i>0 0</i>		IF UNDER 24 HRS. HOURS MIN. <i>0 0</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>			7b. COUNTRY OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>15424 Rowland Lane</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Barber-Hair Stylist</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD</i>				13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>15424 Rowland Lane</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Theodore R. Crutchfield, Sr.</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Daisy Lawrence</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>				16b. SOCIAL SECURITY NO. <i>WWII</i>		17. INFORMANT ADDRESS <i>Same as above</i> <i>Marjorie Crutchfield (Wife)</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <i>Carcinoma Prostate</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>None</i>												
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <i>MD</i>				MEDICAL EXAMINER <i>Dec 28/98</i>				
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers</i>				ADDRESS <i>1919 Seminary Rd. S.S.Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>				23b. DATE <i>Dec. 30, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>		23d. LOCATION CITY OR TOWN <i>Wash. D.C.</i>		COUNTY STATE		
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi</i>						ADDRESS <i>11800 N.H. Ave. S.S.Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 30 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>		

BP

Handwritten text at the top of the page, mostly illegible due to fading.

Second section of handwritten text, appearing as several lines of cursive script.

Third section of handwritten text, continuing the narrative or list.

Fourth section of handwritten text, showing more detail in the script.

Fifth section of handwritten text, located near the bottom of the page.

Vertical stamp or text on the left margin, possibly reading "RECEIVED" or similar.



Small, faint text or markings at the bottom center of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

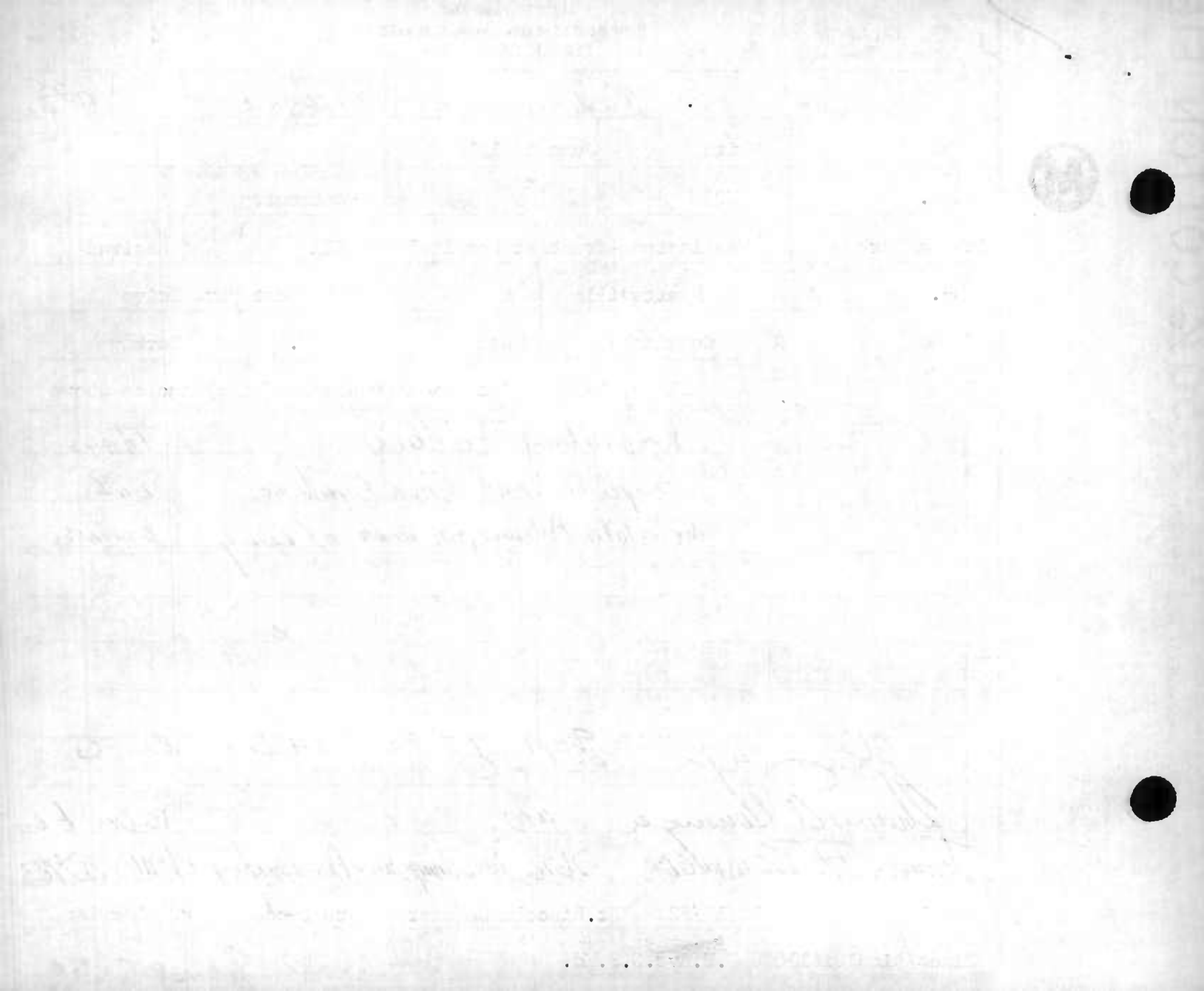
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 3 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert C. Cunningham			2a. DATE OF DEATH MONTH DAY YEAR 12/14/82			2b. HOUR 9:25 PM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 26 1918		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CIA		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. COUNTY PG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7710 West Park Drive			
14. FATHER'S NAME FIRST MIDDLE LAST James R Cunningham				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose M. Berkey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None				16b. SOCIAL SECURITY NO. 210 05 1435		17. INFORMANT ADDRESS Katherine Cunningham (Wife) Same as above			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 1629 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Superior Vena Cava Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Adenocarcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 2 wks 8 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from Sept 7, 1982 to 14 Dec 1982 , that (1) (we) lost saw the deceased alive on 14 Dec 1982 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas A. Bensinger					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 15 Dec 82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas H. Bensinger					22e. ADDRESS 7676 New Hampshire Ave Langley Pk MD 20703				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/18/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi 11800 N.H. Ave. S.S. Md.					25a. DATE REC'D. BY REGISTRAR DEC 16 1982		25b. REGISTRAR'S SIGNATURE John J. Connelley		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 5 3 3	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) NORMAN ALLEN CURTIS						2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 5 1982			2b. HOUR 8:50p M		
3 SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MAY 23 1927		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL, NAVAL MEDICAL CMD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY U. S. NAVY		
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2428 DEXTER AVENUE			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH GEORGE CURTIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE MATILDA KELLEY				16. ADDRESS 2428 DEXTER AVE.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1944-1967		17. INFORMANT MARIE HELENA CURTIS		ADDRESS SILVER SPRING, MD 20902					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA WITH ADVANCED CACHEXIA 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 4 NOVEMBER 1982 to 5 DECEMBER 1982 , that (I) (we) last saw the deceased alive on 5 DECEMBER 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. L. Sollock					DEGREE MD			22c. DATE SIGNED 6 DEC 1982		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. L. SOLLOCK, LCDR, MC, USN					22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20878						
23a. BURIAL, CREMATION, REMOVAL Cremation			23b. DATE Dec 7 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md. Prince Geo.			
24. FUNERAL DIRECTOR W W Chambers Co					25a. DATE REC'D. BY REGISTRAR DEC 10 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 2 5 3 4	
1. DECEASED NAME (TYPE OR PRINT) James Dalrymple										2a. DATE KNOWN OF DEATH Dec 25 19 82		2b. HOUR 5:40 AM	
3. SEX M	4. RACE W	5. DATE OF BIRTH Mar 28 1907	6. AGE (IN YEARS) 75	7. IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0	8. UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN 0	7c. DATE PRONOUNCED DEAD Dec 25 19 82		7d. HOUR 5:40 AM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH St. Louis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President		12b. KIND OF BUSINESS OR INDUSTRY Dominion Forge					
USUAL RESIDENCE (IF IN RESIDENCE HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Ontario		13b. CITY OR TOWN Windsor		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2326 Lincoln Rd.							
14. FATHER'S NAME (FIRST MIDDLE LAST) Robert Dalrymple				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Julia Sneddon									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT Charles Dalrymple-Son ADDRESS 15206 Dumbarton Road Rockville, Md. 20853					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4411 IMMEDIATE CAUSE (a) Ruptured Thoracic Aneurysm DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE John S. Rogers M.D.				TITLE (SPECIFY) Dep. MEDICAL EXAMINER				DATE SIGNED Dec. 25, 1982					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers				ADDRESS Silver Spring, Maryland 20901									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-82		23c. NAME OF CEMETERY OR CREMATORY Victoria Memorial				23d. LOCATION CITY OR TOWN COUNTY STATE Windsor, Ontario Canada					
24. FUNERAL DIRECTOR NAME Francis J. Collins						25a. DATE REC'D. BY REGISTRAR JAN 6 1983		25b. REGISTRAR'S SIGNATURE John S. Rogers					
500 University Blvd. West Silver Spring, Md. 20901													

Office

U.S.A.

President

Commissioner

Robert

Robert

John

John

Charles Johnson, Esq., 1000 Broadway, New York, N.Y. 10003

John S. Rogers

John S. Rogers, 1000 Broadway, New York, N.Y. 10003

Victor Johnson

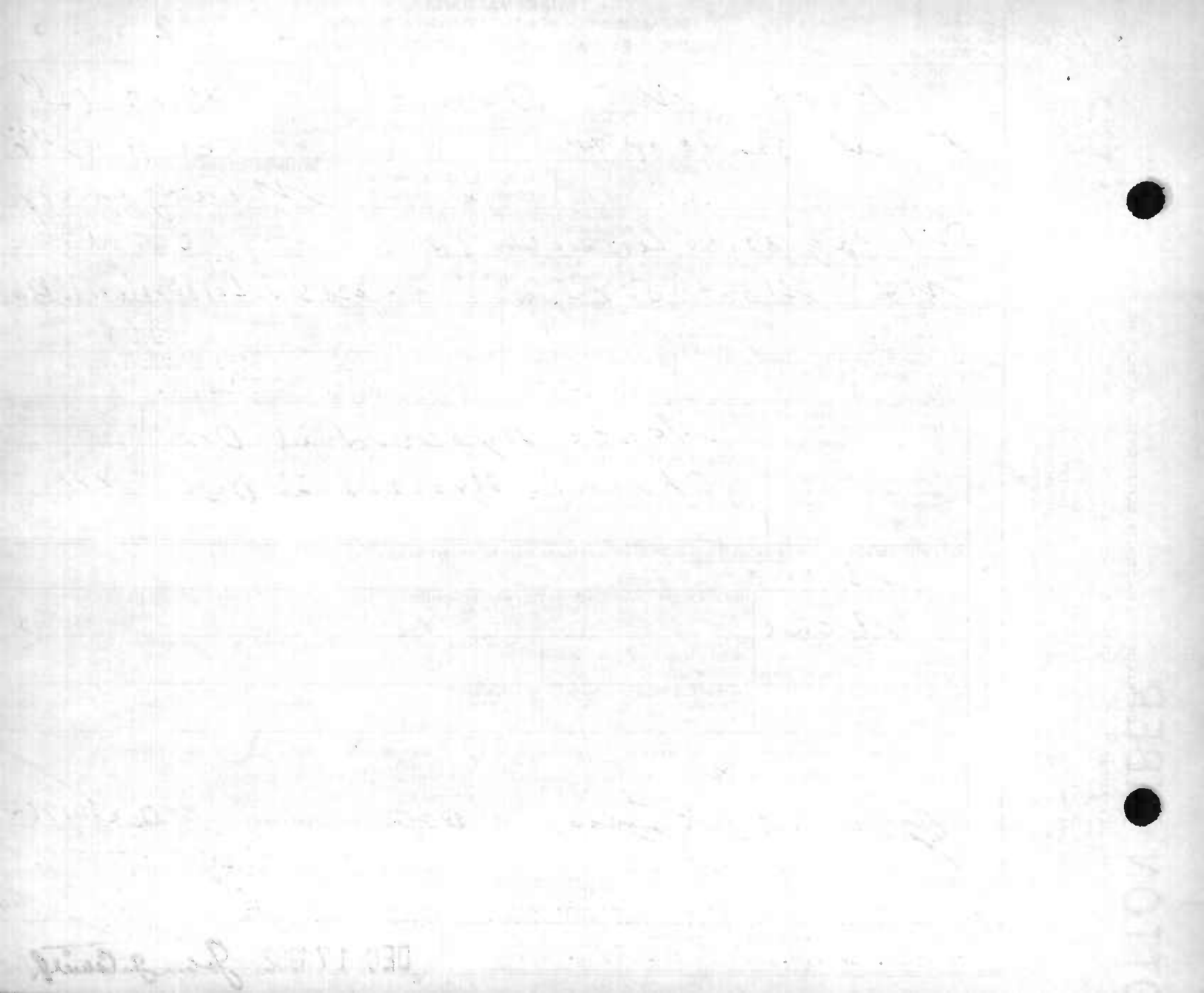
Victor Johnson, 1000 Broadway, New York, N.Y. 10003

1000 Broadway, New York, N.Y. 10003

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ROSE N. DANIEL										2a. DATE KNOWN OF DEATH ESTIMATED Dec 9 1982	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH Jan DAY 10 YEAR 1914	6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Dec 11 1982		2d. HOUR 1130			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3213 S. Leisure World Blvd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY C & P TELEPHONE			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										12c. STREET ADDRESS 20906	
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3213 S. Leisure World Blvd			
14. FATHER'S NAME FIRST MICHAEL MIDDLE CHRISTOFARO LAST DININO				15. MOTHER'S MAIDEN NAME FIRST MARIA MIDDLE DININO LAST DININO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-01-1636		17. INFORMANT SISTER		17b. ADDRESS 5855 SARGENT ROAD CHILLUM, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Disease DUE TO, OR AS A CONSEQUENCE OF (c) None										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D.		MEDICAL EXAMINER John S. Rogers		DATE SIGNED Dec 11, 1982			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS 1919 SEMINARY RD., SILVER SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/14/82		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR DEC 17 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			

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DEC 11 1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 3 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERNEST ELDON DAVENPORT, JR			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 27 1982		2b. HOUR 10:50 P	
3 SEX MALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 29 1922		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OKLAHOMA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY USAF				
13a. STATE VIRGINIA		13b. COUNTY FAIRFAX		13c. CITY OR TOWN ALEXANDRIA		
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST ELDON DAVENPORT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ARLA CRAWFORD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1941-1971		17. INFORMANT BERNICE NEILL DAVENPORT, 8604 CHERRY VALLEY		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2028 IMMEDIATE CAUSE (a) LYMPHOMA WITH HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		LANE, ALEXANDRIA VA 22309		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 27, 19 82 , to DECEMBER 27, 19 82 , that (I) (we) last saw the deceased alive on DECEMBER 27, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Bruce L. Flax		DEGREE PHYSICIAN		22c. DATE SIGNED 12/29/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE L FLAX		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/83		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Weatherford Oklahoma		23e. DATE REC'D. BY REGISTRAR JAN 4 1983				
24. FUNERAL DIRECTOR NAME Lockstone Funeral Home		ADDRESS Weatherford, Oklahoma		25a. DATE REC'D. BY REGISTRAR JAN 4 1983		
				REGISTRAR'S SIGNATURE John J. Carver		

BP _____

RECEIVED
JAN 10 1964
FBI - NEW YORK

11

(M)

CHESTER

20% COTTON

[Faint, mostly illegible text and markings on a grid background, possibly a ledger or form. Some visible words include "RECEIVED", "JAN 10 1964", "FBI - NEW YORK", "CHESTER", and "20% COTTON".]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND (21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 21a & 21b Film 575										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR 1-3-83 cn										NELLIE MARY DAVIS										REG. NO. 32537									
1 DECEASED NAME (TYPE OR PRINT) NELLIE MARY DAVIS										2a DATE KNOWN OF DEATH 10/22/82										2b DATE OF DEATH 10/22/82									
3 SEX Female		4 RACE W		5 DATE OF BIRTH OCT. 22, 1897		6 AGE (IN YEARS) 85		7 IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8 IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		9 DATE PRONOUNCED DEAD Dec 7 1982		10 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		11 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife		12 KIND OF BUSINESS OR INDUSTRY Home											
13a STATE Md.				13b CITY OR TOWN Mont.				13c INSIDE CITY LIMITS? YES NO				13d STREET ADDRESS 617 Olney-Sandy Spring Rd				14 FATHER'S NAME William - MIDDLE LAST Gregg				15 MOTHER'S MAIDEN NAME Margaret Catherine Stream									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b SOCIAL SECURITY NO. 218-34-6201				17 INFORMANT Cynthia Gregg				18 ADDRESS Rockville, Md. 20852				19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 1/2 mo																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost										(b) Fracture L. hip.																			
(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Fracture L. hip																													
19a DATE OF OPERATION 2-28-82										19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture L. hip										20 AUTOPSY? YES NO									
21a EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 2 24 19 82										21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall at home									
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK										21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home										21f LOCATION (CITY OR TOWN, STREET, COUNTY, STATE) Olney/Sandy Sp. Rd. Sandy Sp. Mont. Md.									
22a I certify that I took charge of the remains described above, held an autopsy inspection inquiry and in my opinion death resulted from: Natural causes Accident X Suicide Homicide Undetermined manner										TITLE (SPECIFY) Dr. John S. Rogers M.D. MEDICAL EXAMINER										DATE SIGNED Dec 7 1982									
ACTUAL SIGNATURE Dr. John S. Rogers										ADDRESS Silver Spring, Md.																			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b DATE Dec. 9, 1982										23c NAME OF CEMETERY OR CREMATORY Burtonsville									
24 FUNERAL DIRECTOR FRANCIS H. BARBER										25a DATE REC'D. BY REGISTRAR John J. Smith										25b ADDRESS OF REGISTRAR'S OFFICE Burtonsville, Mont. Md.									

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR		Ethel P. Davison		CERTIFICATE OF DEATH		REG. NO. 8 2 3 2 5 3 8			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
ETHEL P. DAVISON				12-9-82		6:40		A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		Jan. 14, 1897		85		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Ohio		U.S.A.				Mont. MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chevy Chase		Beth. Ret. & Nursing Ctr.				Clerk		U.S. Govt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Md. 20815				Mont.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8700 Jones Mill Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Edward		Anna		No		298-10-7967		T. Embury Jones 1001 Rookwood Dr. Cinn. O.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4140 IMMEDIATE CAUSE (a) Cardiac arrest								2 hr	
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac disease								2 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 18, 1982, to Dec 9, 1982, that (we) lost the deceased alive on Nov 10, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
William H. Kellay, M.D.				3rd Fitzgerald M.D.				Dec 9 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
William H. Kellay, M.D.				8218 Wisc. Ave. Beth., M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Cremation		12/9/82		Cedar Hill Crematory		Suitland, Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C. 20016				DEC 13 1982		John J. Coburn			



1. Davidson

2. Davidson

Female

White

Jan. 1, 1897

85

Ohio

U.S.A.

x

Mont. Mine

Heavy Chain

Barb. Net. Hanging Out.

Black

U.S. Govt.

17. 700 15 Mont.

x Heavy Chain

6700 Jones Hill Rd.

Edward

Petite

Anna

Mont.

No

208-14-0007

T. Jimmy Jones 1001 Jackson St. Mont. D.



11114

3278

12-10-98

John Hill & Son, Inc.

2100

2100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 3 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HILBERT HARIWELL DAWSON			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 5 1982			2b. HOUR 1:45p_M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 2 1921		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF ADMIT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL, NAVAL MEDICAL CMD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
13a. STATE VIRGINIA			13b. COUNTY FAIRFAX		13c. CITY OR TOWN ANNANDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST LONAL BURRELL DAWSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL PEARL BAGGETT			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			
16b. SOCIAL SECURITY NO. 1942-1963			17. INFORMANT EMILY NEILL DAWSON			ADDRESS 5108 PHILLIP ROAD ANNANDALE VA 22003			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

5715

IMMEDIATE CAUSE (a) **SEPSIS**

DUE TO, OR AS A CONSEQUENCE OF

(b) **CIRRHOSIS**

DUE TO, OR AS A CONSEQUENCE OF

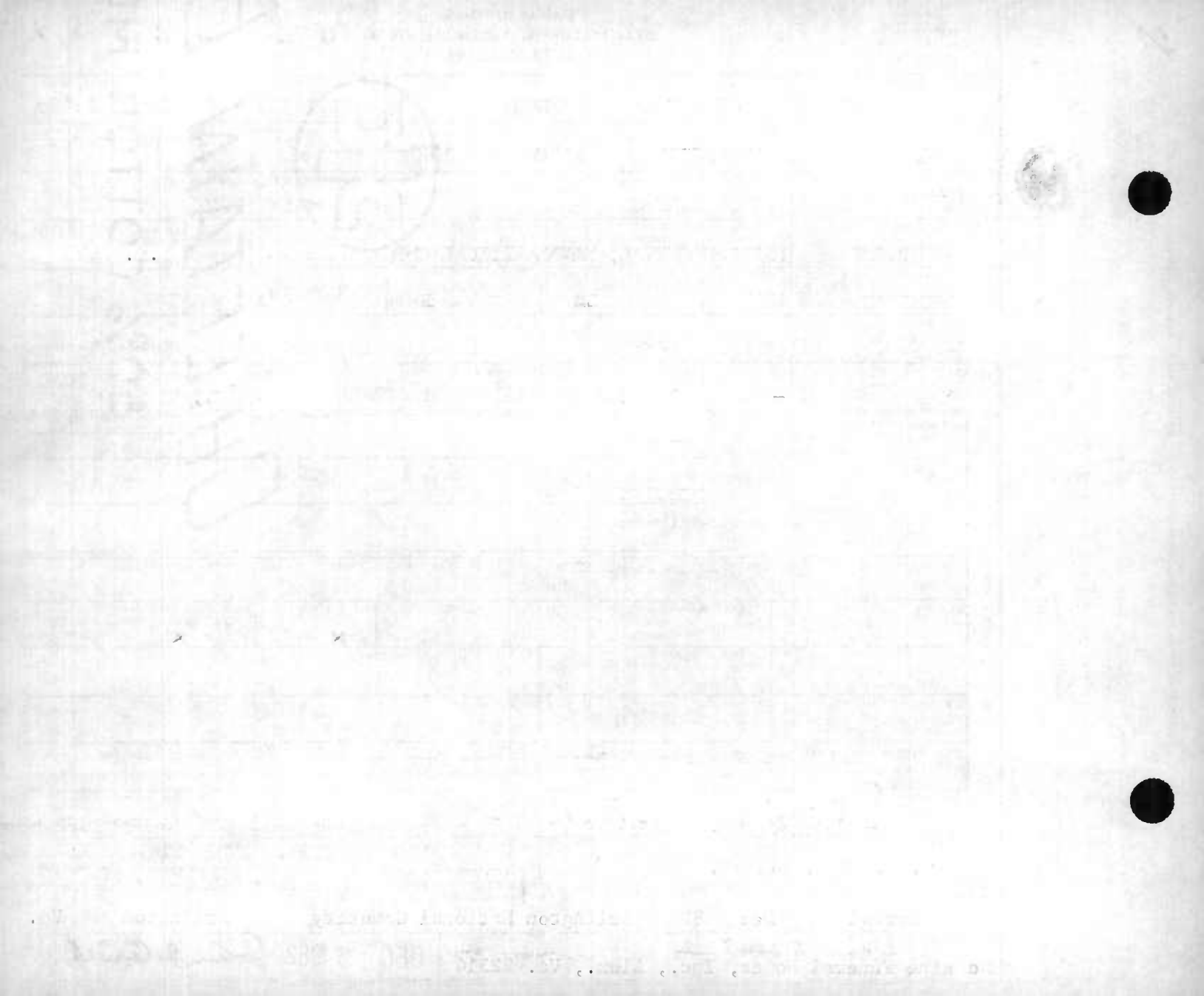
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 25 NOVEMBER 19 82 to 5 DECEMBER 19 82 , that (I) (we) lost saw the deceased alive on 5 DECEMBER 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. L. REED, LT, MC, USNR				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6 DEC 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. L. REED, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20878			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 9 82		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.	
24. FUNERAL DIRECTOR NAME Wayne F. Flad ADDRESS Demaine Funeral Homes, Inc., Alex., Va. 22314				25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE DEC 13 1982 <i>John J. Canale</i>			



BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 3 2 5 4 0									
1. FOR STATE REGISTRAR					REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Dilworth Day					2a. DATE OF DEATH MONTH DAY YEAR Dec. 6 1982					2b. HOUR 8 A M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 2, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 89		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.								
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE D.C. 20008		13b. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2801 - 31st St. N.W.								
14. FATHER'S NAME FIRST MIDDLE LAST Llewellyn Apr Roger Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Wisner										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-50-2682		17. INFORMANT ADDRESS Gertrude Enemark Same as Item # 13										
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 5 years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (the hospital) attended the deceased from Jan. 1 , 19 82 , to Dec. 6 , 19 82 , that (I) (we) lost saw the deceased alive on Nov. 28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE CR Gruver				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/6/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clifton Gruver, M.D.				22e. ADDRESS 1145--19th St., N.W. Wash., D.C.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/7/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.								
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) DEC 10 1982 John J. Gawler								



NOV 11 1950

11-11-50

Clifton Brown, N.Y.

Clifton, N.Y.

Clifton, N.Y.

Clifton, N.Y.

Clifton, N.Y.

Clifton, N.Y.

Clifton, N.Y.

Clifton, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 4 1			
FOR 1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ANNE MARGUERITE DEAN				2a. DATE OF DEATH MONTH DAY YEAR 12-27-82		2b. HOUR 3:20 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 23, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS) Althea Woodland Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK OR FORM OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Barrenburg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Windels		13e. STREET ADDRESS 7611 Lynn Drive 20815			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217 42 8204		17. INFORMANT ADDRESS 4617 Saul Road Kensington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CEREBRO-VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Generalized ARTERIOSCLEROSIS (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 19 70 to Dec 27 19 82 , that (I) (we) last saw the deceased alive on Dec 27 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernard A. Fitzgerald M.D. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-27-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD				22e. ADDRESS 217 UNIVERSITY BLVD E, SILVER SPRING, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland 20851	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR 10N 5198 25b. REGISTRAR'S SIGNATURE John J. Cawley			

BP

1970 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 3 2 5 4 2			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) Clarice Ellen DeBevec					2a. DATE OF DEATH MONTH DAY YEAR December 10, 1982					2b. HOUR 2:00A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 31, 1922			6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Dakota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.						
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 509 Meadow Hall Drive					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Licensed Registered Nurse			12b. KIND OF BUSINESS OR INDUSTRY Health			
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 509 Meadow Hall Drive		
14. FATHER'S NAME FIRST MIDDLE LAST George Joseph Schneider					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MaryAnn Shannon								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) \$38-26-3739		17. INFORMANT (Husband) ^{AD 509} Charles J. DeBevec					509 Meadow Hall Dr Rockville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 1519 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Stomach</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>2 years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/9/82</u> , 19____, to <u>12/10/82</u> , 19____, that (I) (we) lost saw the deceased alive on <u>12/26/82</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Jeremy V. Cooke</u>				DEGREE <u>MD</u>				22c. DATE SIGNED Dec. 10 1982					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jeremy V. Cooke</u>				22e. ADDRESS 10400 Connecticut Avenue Kensington, Maryland 20895									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE December 11, 1982		23c. NAME OF CEMETERY OR CREMATORY Crematory Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, PA, Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR DEC 13 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>					

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 5 4 3			
FOR 1 - STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
Philip J DeGrouchy				12 2 82			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
male		Caucasian		MONTH DAY YEAR		69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
New York		USA				Montgomery County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital		Sheet metal		Retired	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland						Beltsville	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Philip J. DeGrouchy				Catherine Knecht			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				578-01-9026		Jim DeGrouchy 536 Vanderbilt Av. Virginia Bch Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma, primary undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 months</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>July 12/1</u> 19 <u>82</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James Coleman MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-2-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R. COLEMAN				22e. ADDRESS 6241 COLUMBIA BLVD SILVER SPRING, MD. 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal		12-2-82		Georgetown Medical Sch.		Washington, D.C.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Columbia Mortuary Services				225 Missouri Av Washington, D.C.		DEC 9 1982 <u>John J. Canfield</u>	

BP



New York

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Emerson

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Library

Belleville

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Belleville, Pennsylvania

Belleville

Belleville

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Library

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Belleville, Pennsylvania

Belleville, Pennsylvania

Belleville, Pennsylvania

Belleville, Pennsylvania

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5. RETURN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

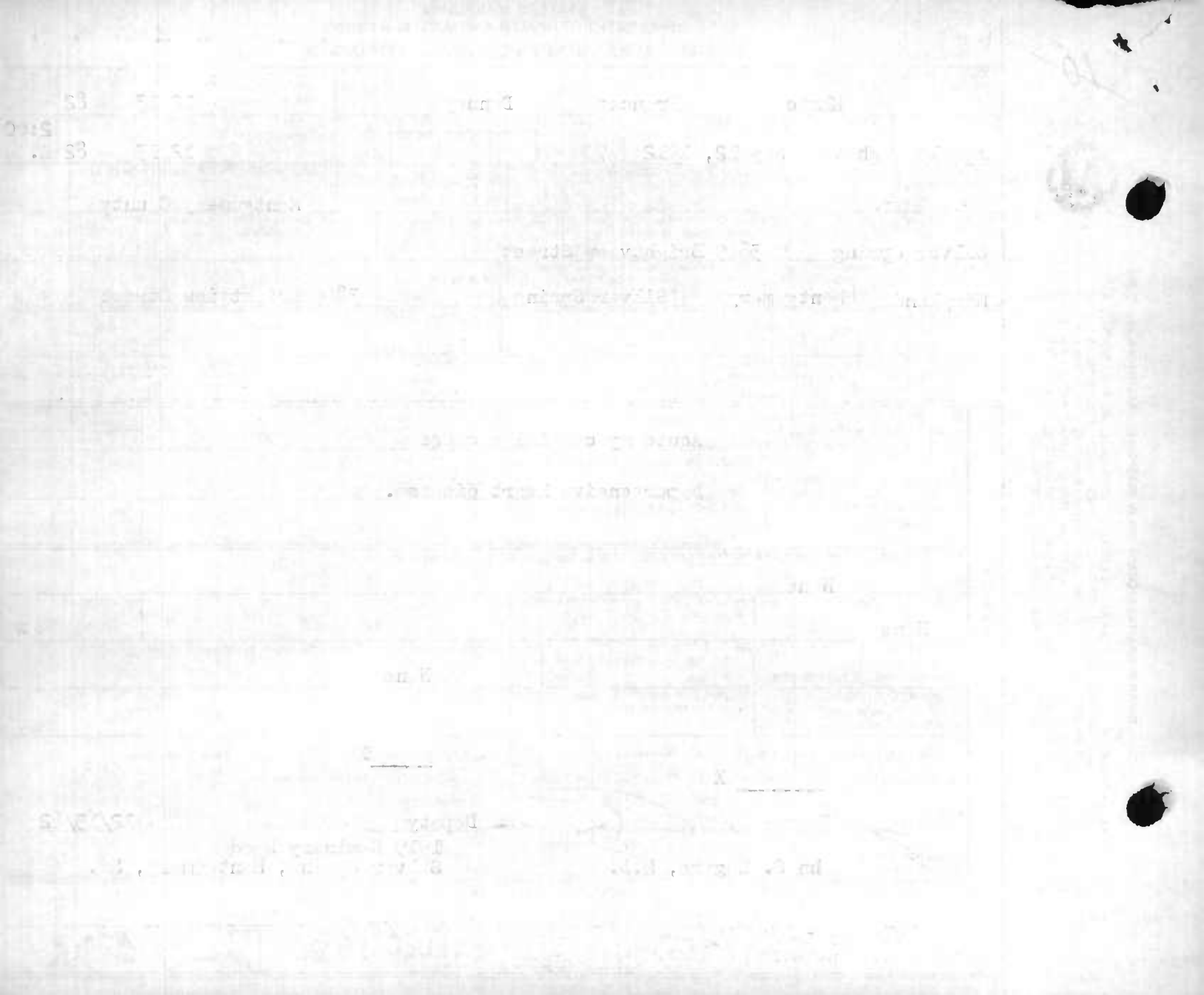
BP

DMMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE KNOWN OF DEATH		7. MONTH	
Elsie Frances Denney								12/13		82	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD		10. MONTH		11. DAY	
Female	White	3 MONTH 8 DAY 1912	70 YRS.			12/13		19		82	
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		13. CITIZEN OF WHAT COUNTRY?		14. MARRIED		15. NEVER MARRIED		16. BALTIMORE CITY OR COUNTY OF DEATH		17. MD.	
New York		U. S. A.		WIDOWED		DIVORCED		Montgomery County			
18. CITY OR TOWN OF DEATH		19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		21. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		3809 Brightview Street		Housewife		Own Home					
22. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		23. STATE		24. CITY OR TOWN		25. INSIDE CITY LIMITS?		26. STREET ADDRESS			
		Maryland		Montgomery		YES X NO		3809 Brightview Street		20902	
27. FATHER'S NAME		28. MOTHER'S MAIDEN NAME		29. CITY OR TOWN		30. STREET ADDRESS					
Fred Bryant		Frances Neineger		Silver Spring		3809 Brightview St					
31. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		32. SOCIAL SECURITY NO.		33. INFORMANT		34. ADDRESS					
No		108-14-0223		Warren W. Denney		Sil. Spr., Md.					
35. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
4029 IMMEDIATE CAUSE (a) Acute myocardial disease											
DUE TO, OR AS A CONSEQUENCE OF											
(b) hypertensive heart disease.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
None											
36. DATE OF OPERATION		37. CONDITION FOR WHICH OPERATION WAS PERFORMED?		38. AUTOPSY?							
None				YES NO X							
39. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		40. TIME OF INJURY		41. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19		None							
42. INJURY OCCURRED WHILE AT WORK		43. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		44. LOCATION		CITY OR TOWN		COUNTY		STATE	
NOT WHILE AT WORK				STREET							
45. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.											
46. ACTUAL SIGNATURE											
47. EXAMINER'S NAME (TYPE OR PRINT)											
John S. Rogers, M.D.											
48. TITLE (SPECIFY)											
Deputy											
49. MEDICAL EXAMINER											
1919 Seminary Road											
Silver Spring, Montgomery, Md.											
50. DATE SIGNED											
12/13/82											
51. BURIAL, CREMATION, REMOVAL (SPECIFY)		52. DATE		53. NAME OF CEMETERY OR CREMATORY		54. LOCATION		CITY OR TOWN		COUNTY	
Burial		12/15/82		Mt. Olivet Cemetery		Washington, D. C.					
55. FUNERAL DIRECTOR		56. P.O. Box		57. BY REGISTRAR		58. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc.		428		DEC 16 1982		John J. Carver					
59. ADDRESS		60. CITY OR TOWN		61. COUNTY		62. STATE					
Sil. Spr., Md.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 410-358-1600.

BP _____

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 4 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BESSIE R. DENTON			2a. DATE OF DEATH MONTH DAY YEAR 12 20 82			2b. HOUR 10:45 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 16 1904		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 20852 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7303 Old Stage Road	
14. FATHER'S NAME FIRST MIDDLE LAST Morton Rissler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annetta Walker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 500-44-7929		17. INFORMANT ADDRESS Robert H. Denton. 8600 International Ave., Canoga Park, Calif.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebrovascular Accident 4273 DUE TO, OR AS A CONSEQUENCE OF (b) Atrial fibrillation? DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/18/82 , 19 82 , to 12/20 , 19 82 , that (I) (we) last saw the deceased alive on 12/19/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE K. Nossuli				DEGREE M.D.		22c. DATE SIGNED 12/20/1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. KALDUN NOSSULI				22e. ADDRESS 11500 Old Georgetown Rd.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/1982		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION Brentwood Maryland	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR DEC 27 1982			
				25b. REGISTRAR'S SIGNATURE John J. Gawler			

SECRET

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7505 Old State Road

121. 5085 Northmontery Rockville

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Or

255-4-12

Robert A. Denton, 8600 International
Canons Park,

London Park, 1912.

2050

5821/05/51

DATE: 05/05/2015 10:05 AM

U.S. DEPARTMENT OF JUSTICE

0102230

John J. Smith

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 4 6

FOR
1- STATE
REGISTRAR

REG. NO.

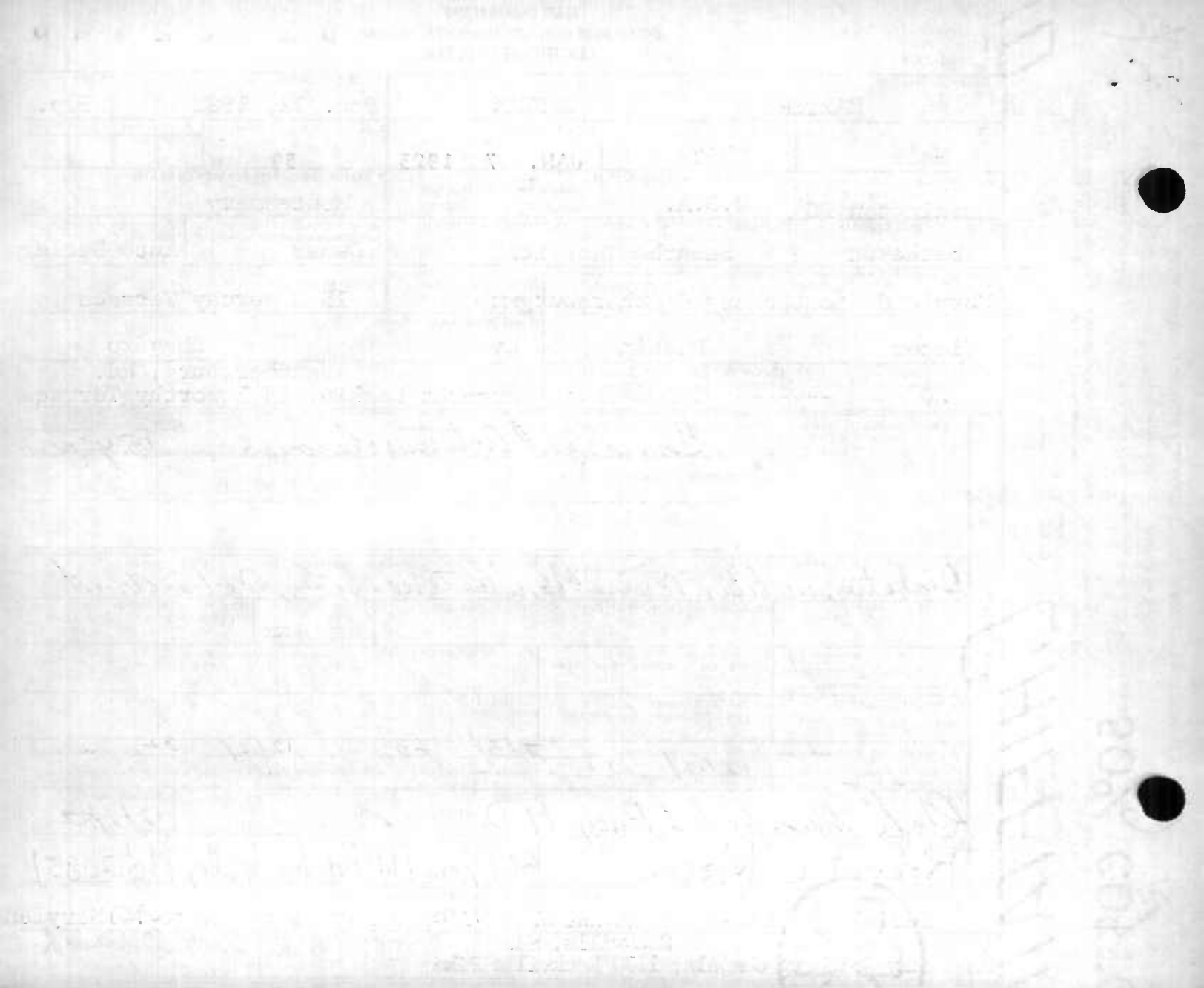
1. DECEASED NAME (TYPE OR PRINT) MARTIN DESKIN			2a. DATE OF DEATH MONTH DAY YEAR Dec. 12, 1982		2b. HOUR 4:50 p.m.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR JAN. 7 1923		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner	12b. KIND OF BUSINESS OR INDUSTRY Auto Dealer	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 15 Esworthy Terrace
14. FATHER'S NAME FIRST MIDDLE LAST Victor Deskin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Shapiro			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-18-6923A		17. INFORMANT Gaithersburg, Md. Margaret Deskin; 15 Esworthy Terrace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus, Cerebral Vascular Arteriosclerosis, Cardiac Arrest.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/13/ 1982 to 12/12/ 1982 , that (I) (we) lost saw the deceased alive on 12/12/ 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert C. Macon for D. I. Bucy		DEGREE M.D.		22c. DATE SIGNED 12/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Macon		22e. ADDRESS 809 Viers Mill Rd. Rockville, Md. 20851			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-15-82	23c. NAME OF CEMETERY OR CREMATORY RESTHAVEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick; Frederick C; Maryland	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		25a. DATE REC'D. BY REGISTRAR DEC 16 1982		25b. REGISTRAR'S SIGNATURE John J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

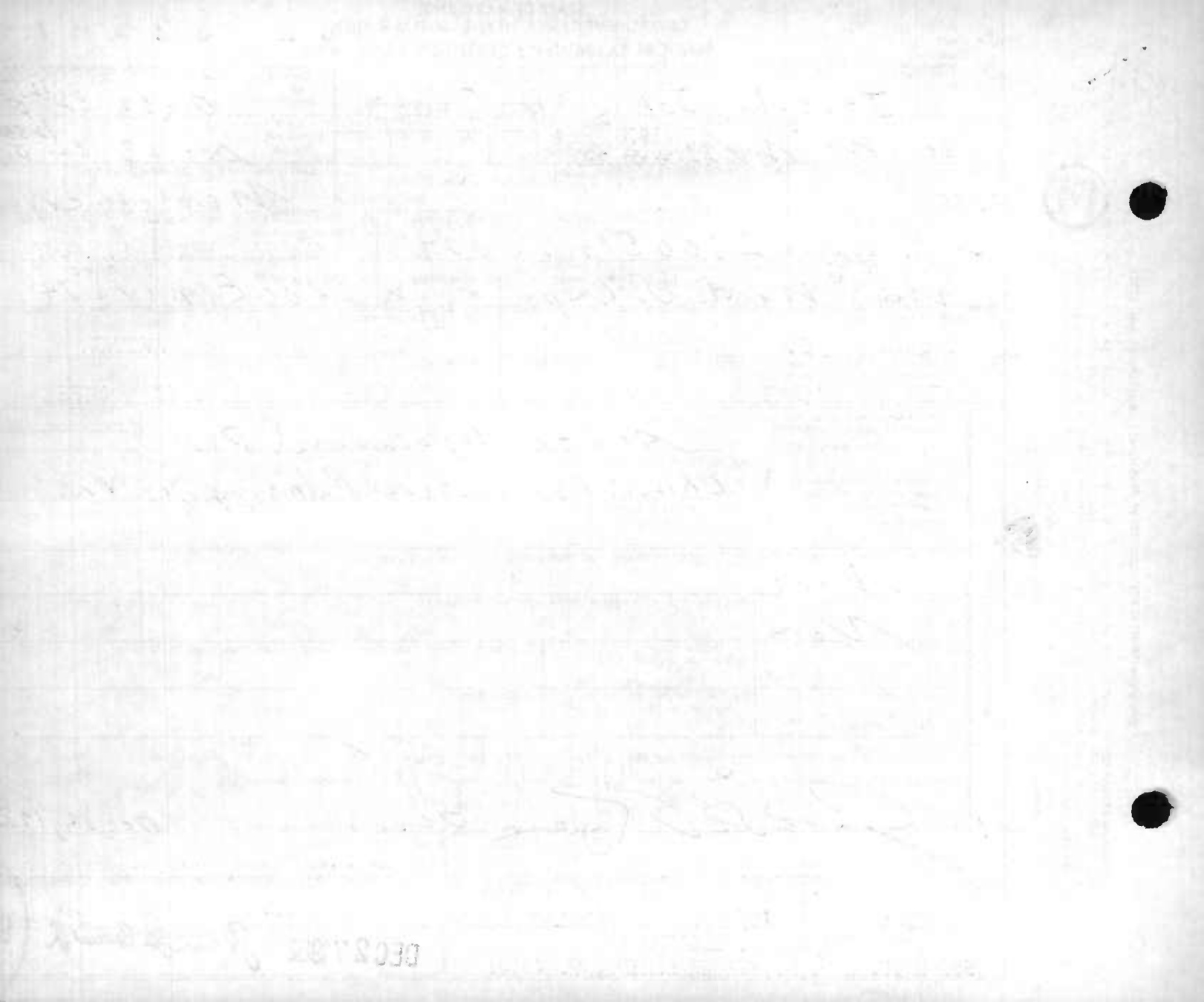
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 2. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 5 2 3 2 5 4 7	
1. DECEASED NAME (TYPE OR PRINT) Joseph John DiCARLO			2a. DATE KNOWN OF DEATH ESTIMATED Dec 23 19 82			2b. HOUR OF DEATH 12:00 PM					
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 11 DAY 23 YEAR 1913	6. AGE IN YEARS 69	7. IF UNDER 1 YR. MONTHS 6 DAYS 14 HOURS 12 MIN.	8. IF UNDER 24 HRS. HOURS 12 MIN.	2c. DATE PRONOUNCED DEAD Dec 23 19 82		2d. HOUR OF DEATH 12:00 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LOUISIANA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OF RESIDENCE AT DEATH WHEATON			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2800 Elmview St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POSTAL CLERK			12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT		
13a. STATE MD			13b. CITY OR TOWN Montgomery			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS 2800 Elmview St.		
14. FATHER'S NAME FIRST JOSEPH MIDDLE J. LAST DiCARLO			15. MOTHER'S MAIDEN NAME FIRST ROSE MIDDLE MATRANGA LAST MATRANGA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT ANNA DiCARLO			ADDRESS SAME AS 13 WIFE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4960 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Obstructive Pulmonary Dis. Xrs. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers			TITLE (SPECIFY) MD						DATE SIGNED Dec 23, 1982		
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS			ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/27/82			23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D BY REGISTRAR DEC 27 1982			25b. REGISTRAR'S SIGNATURE John J. Smith		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 4 8

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel V. Dixon			2a. DATE OF DEATH MONTH DAY YEAR 12/15/82		2b. HOUR 9:15 AM					
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2/04/09		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10702 DOUGLAS AVENUE 20902	
14. FATHER'S NAME FIRST MIDDLE LAST FITZHUGH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE TIPPET							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-24-2489		17. INFORMANT FULTON H. DIXON		ADDRESS SAME AS 13 HUSBAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GI bleed</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 days 10 hrs 20 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/4</u> 19 <u>82</u> , to <u>12/5</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12/4</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) signed this report after viewing the body after death.										
22b. SIGNATURE Francis J. Collins				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/15/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Francis J. Collins				22e. ADDRESS 10301 Georgia Ave, #57, Hk						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/8/82		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRI GEO MD.				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				24b. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR DEC 8 - 1982		25b. REGISTRAR'S SIGNATURE John J. Canine		

MEDICAL CERTIFICATION

BP

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 4 9

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mary M. Donlin				2a. DATE OF DEATH MONTH DAY YEAR 12 27 82				2b. HOUR 1:05 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 20 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY I.B.E.W.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 20015				13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Donlin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Kelly				13e. STREET ADDRESS 5437 Conn. Ave., N.W.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 212-26-8000		17. INFORMANT ADDRESS Beulah P. Donlin. 610 Cooks Lane, Baltimore Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1519 IMMEDIATE CAUSE (a) Carcinoma of the stomach DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a _____									
19a. DATE OF OPERATION 12-10-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of stomach				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-2-82 , 19 82 , to 12-27 , 19 82 that (I) (we) last saw the deceased alive on 12-26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. P. McCarrick M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. P. McCARRICK				22e. ADDRESS 809 Viers Mill Rd. Rockville Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/30/1982		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc.				ADDRESS 5130 Wisc. Ave., N.W. Wash., DC.		25a. DATE REC'D. BY REGISTRAR JAN 3 1983		25b. REGISTRAR'S SIGNATURE John J. Gawler	

No. 512-20-000 Serial P. Donlin. 610 Court Lane, Baltimore
 Michael Donlin
 D.O. 20015
 3437 Conn. Ave., N.W.
 Supervisor
 U.S.A.
 U.S.A.
 White
 Feb. 20 1903
 79

12/10/1963 M. Oliver Cemetery Washington D.C.
 Joseph Donlin's Plot Int.
 1100 1st. Ave. N.E. Wash. D.C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Grace E. Dorney		2a. DATE OF DEATH MONTH DAY YEAR 12 21 82		2b. HOUR 10 36 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 31, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Potomac	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11910 Glen Mill Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Legal Secretary	12b. KIND OF BUSINESS OR INDUSTRY Law
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Gering		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Munda		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 097-01-0015		17. INFORMANT Potomac, Md. 20854 Grace A. Koppel, 11910 Glen Mill Rd.,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Histiocytic Lymphoma (1-82) 2000 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 months
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Nov. 9 , 19 82 , to Dec 21 , 19 82 , that (I) (we) last saw the deceased alive on Dec 20 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Albert E. Rolle, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert E. Rolle, M.D.				22e. ADDRESS (202) 529-8083 1140 Varnum St. N.E., D.C.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 22, 1982	23c. NAME OF CEMETERY OR CREMATORY St. Gabriel's Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Potomac Maryland
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		25a. DATE REC'D. BY REGISTRAR DEC 27 1982	
P.A. Rockville, Maryland		25. REGISTRAR'S SIGNATURE John J. Connel	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

19

11/1/52

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 5 1			
1. DECEASED NAME (TYPE OR PRINT) TALBERT. E. DOWLING.				REG. NO.			
2a. DATE OF DEATH MONTH DAY YEAR 12-2-1982				2b. HOUR 3:05 A.M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2-2-1884		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Takoma PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Messenger, Superv.		12b. KIND OF BUSINESS OR INDUSTRY US Treasury	
13a. STATE Maryland		13b. CITY OR TOWN Pr. Georges Hyattsville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4922 LaSalle Road	
14. FATHER'S NAME FIRST MIDDLE LAST Meade Dowling		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Chew					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-18-7236T		17. INFORMANT ADDRESS Mary D. Fields, 3003 VanNess St. N.W., Wash. DC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4110 IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Chronic Obstructive Pulmonary Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/24/82 to 12/2/82 , 19 82 , that (I) (we) last saw the deceased alive on 12/1/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Howard W. Kenney, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/2/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard W. Kenney, M.D.		22e. ADDRESS 1115 Spring St. Silver Spring, MD 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 6, 1982		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Highland Park, Pr. Geo., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS McGuire Funeral Serv, Inc, 7400 Georgia Ave. N.W.		25a. DATE REC'D. BY REGISTRAR DEC 13 1982		25b. REGISTRAR'S SIGNATURE John J. Conner			

2022-08-10 14:18

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DEC 1 2022

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Asatella M M N</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>12-8-82</i>			2b. HOUR <i>6:20 a.m.</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>DEC 4 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>73</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PENNA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.			
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEMAKER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>MONT.</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>501 MARGARET DRIVE</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>ALEXANDER</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY JANE TWEEDEY</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>207-24-6860</i>		17. INFORMANT ADDRESS <i>CAROLE ANK-501 MARGARET DR. S.S. MD</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-renal arrest</i> <i>4280</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>congestive heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>renal T.S.S.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-3 yrs</i> <i>1 year</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Gen. arteriosclerosis Diabetes mellitus</i>									
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <i>Jan 1970</i> , to <i>Dec 8</i> , 19 <i>82</i> , that (1) (we) lost saw the deceased alive on <i>Dec 7</i> , 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death.									
22b. SIGNATURE <i>R.N. Sandstrom</i> MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>12-8-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.N. Sandstrom</i>				22e. ADDRESS <i>7701 Carroll Ave Takoma Park, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		23b. DATE <i>DEC. 11, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lenox Lincoln Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>North Huntingdon Penna</i>			
24. FUNERAL DIRECTOR NAME <i>William Walters</i>				24b. ADDRESS <i>Takoma Park House 254 Carroll St. N.W. Wash. D.C.</i>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>DEC 13 1982 John J. Conner</i>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE MEDICAL EXAMINER. GIVE PAGES 7, 8, AND 9 TO THE FUNERAL DIRECTOR. GIVE PAGES 10, 11, AND 12 TO THE MEDICAL EXAMINER. GIVE PAGES 13, 14, AND 15 TO THE FUNERAL DIRECTOR. GIVE PAGES 16, 17, AND 18 TO THE MEDICAL EXAMINER. GIVE PAGES 19, 20, AND 21 TO THE FUNERAL DIRECTOR. GIVE PAGES 22, 23, AND 24 TO THE MEDICAL EXAMINER. GIVE PAGES 25, 26, AND 27 TO THE FUNERAL DIRECTOR. GIVE PAGES 28, 29, AND 30 TO THE MEDICAL EXAMINER. GIVE PAGES 31, 32, AND 33 TO THE FUNERAL DIRECTOR. GIVE PAGES 34, 35, AND 36 TO THE MEDICAL EXAMINER. GIVE PAGES 37, 38, AND 39 TO THE FUNERAL DIRECTOR. GIVE PAGES 40, 41, AND 42 TO THE MEDICAL EXAMINER. GIVE PAGES 43, 44, AND 45 TO THE FUNERAL DIRECTOR. GIVE PAGES 46, 47, AND 48 TO THE MEDICAL EXAMINER. GIVE PAGES 49, 50, AND 51 TO THE FUNERAL DIRECTOR. GIVE PAGES 52, 53, AND 54 TO THE MEDICAL EXAMINER. GIVE PAGES 55, 56, AND 57 TO THE FUNERAL DIRECTOR. GIVE PAGES 58, 59, AND 60 TO THE MEDICAL EXAMINER. GIVE PAGES 61, 62, AND 63 TO THE FUNERAL DIRECTOR. GIVE PAGES 64, 65, AND 66 TO THE MEDICAL EXAMINER. GIVE PAGES 67, 68, AND 69 TO THE FUNERAL DIRECTOR. GIVE PAGES 70, 71, AND 72 TO THE MEDICAL EXAMINER. GIVE PAGES 73, 74, AND 75 TO THE FUNERAL DIRECTOR. GIVE PAGES 76, 77, AND 78 TO THE MEDICAL EXAMINER. GIVE PAGES 79, 80, AND 81 TO THE FUNERAL DIRECTOR. GIVE PAGES 82, 83, AND 84 TO THE MEDICAL EXAMINER. GIVE PAGES 85, 86, AND 87 TO THE FUNERAL DIRECTOR. GIVE PAGES 88, 89, AND 90 TO THE MEDICAL EXAMINER. GIVE PAGES 91, 92, AND 93 TO THE FUNERAL DIRECTOR. GIVE PAGES 94, 95, AND 96 TO THE MEDICAL EXAMINER. GIVE PAGES 97, 98, AND 99 TO THE FUNERAL DIRECTOR. GIVE PAGES 100, 101, AND 102 TO THE MEDICAL EXAMINER. GIVE PAGES 103, 104, AND 105 TO THE FUNERAL DIRECTOR. GIVE PAGES 106, 107, AND 108 TO THE MEDICAL EXAMINER. GIVE PAGES 109, 110, AND 111 TO THE FUNERAL DIRECTOR. GIVE PAGES 112, 113, AND 114 TO THE MEDICAL EXAMINER. GIVE PAGES 115, 116, AND 117 TO THE FUNERAL DIRECTOR. GIVE PAGES 118, 119, AND 120 TO THE MEDICAL EXAMINER. GIVE PAGES 121, 122, AND 123 TO THE FUNERAL DIRECTOR. GIVE PAGES 124, 125, AND 126 TO THE MEDICAL EXAMINER. GIVE PAGES 127, 128, AND 129 TO THE FUNERAL DIRECTOR. GIVE PAGES 130, 131, AND 132 TO THE MEDICAL EXAMINER. GIVE PAGES 133, 134, AND 135 TO THE FUNERAL DIRECTOR. GIVE PAGES 136, 137, AND 138 TO THE MEDICAL EXAMINER. GIVE PAGES 139, 140, AND 141 TO THE FUNERAL DIRECTOR. GIVE PAGES 142, 143, AND 144 TO THE MEDICAL EXAMINER. GIVE PAGES 145, 146, AND 147 TO THE FUNERAL DIRECTOR. GIVE PAGES 148, 149, AND 150 TO THE MEDICAL EXAMINER. GIVE PAGES 151, 152, AND 153 TO THE FUNERAL DIRECTOR. GIVE PAGES 154, 155, AND 156 TO THE MEDICAL EXAMINER. GIVE PAGES 157, 158, AND 159 TO THE FUNERAL DIRECTOR. GIVE PAGES 160, 161, AND 162 TO THE MEDICAL EXAMINER. GIVE PAGES 163, 164, AND 165 TO THE FUNERAL DIRECTOR. GIVE PAGES 166, 167, AND 168 TO THE MEDICAL EXAMINER. GIVE PAGES 169, 170, AND 171 TO THE FUNERAL DIRECTOR. GIVE PAGES 172, 173, AND 174 TO THE MEDICAL EXAMINER. GIVE PAGES 175, 176, AND 177 TO THE FUNERAL DIRECTOR. GIVE PAGES 178, 179, AND 180 TO THE MEDICAL EXAMINER. GIVE PAGES 181, 182, AND 183 TO THE FUNERAL DIRECTOR. GIVE PAGES 184, 185, AND 186 TO THE MEDICAL EXAMINER. GIVE PAGES 187, 188, AND 189 TO THE FUNERAL DIRECTOR. GIVE PAGES 190, 191, AND 192 TO THE MEDICAL EXAMINER. GIVE PAGES 193, 194, AND 195 TO THE FUNERAL DIRECTOR. GIVE PAGES 196, 197, AND 198 TO THE MEDICAL EXAMINER. GIVE PAGES 199, 200, AND 201 TO THE FUNERAL DIRECTOR. GIVE PAGES 202, 203, AND 204 TO THE MEDICAL EXAMINER. GIVE PAGES 205, 206, AND 207 TO THE FUNERAL DIRECTOR. GIVE PAGES 208, 209, AND 210 TO THE MEDICAL EXAMINER. GIVE PAGES 211, 212, AND 213 TO THE FUNERAL DIRECTOR. GIVE PAGES 214, 215, AND 216 TO THE MEDICAL EXAMINER. GIVE PAGES 217, 218, AND 219 TO THE FUNERAL DIRECTOR. GIVE PAGES 220, 221, AND 222 TO THE MEDICAL EXAMINER. GIVE PAGES 223, 224, AND 225 TO THE FUNERAL DIRECTOR. GIVE PAGES 226, 227, AND 228 TO THE MEDICAL EXAMINER. GIVE PAGES 229, 230, AND 231 TO THE FUNERAL DIRECTOR. GIVE PAGES 232, 233, AND 234 TO THE MEDICAL EXAMINER. GIVE PAGES 235, 236, AND 237 TO THE FUNERAL DIRECTOR. GIVE PAGES 238, 239, AND 240 TO THE MEDICAL EXAMINER. GIVE PAGES 241, 242, AND 243 TO THE FUNERAL DIRECTOR. GIVE PAGES 244, 245, AND 246 TO THE MEDICAL EXAMINER. GIVE PAGES 247, 248, AND 249 TO THE FUNERAL DIRECTOR. GIVE PAGES 250, 251, AND 252 TO THE MEDICAL EXAMINER. GIVE PAGES 253, 254, AND 255 TO THE FUNERAL DIRECTOR. GIVE PAGES 256, 257, AND 258 TO THE MEDICAL EXAMINER. GIVE PAGES 259, 260, AND 261 TO THE FUNERAL DIRECTOR. GIVE PAGES 262, 263, AND 264 TO THE MEDICAL EXAMINER. GIVE PAGES 265, 266, AND 267 TO THE FUNERAL DIRECTOR. GIVE PAGES 268, 269, AND 270 TO THE MEDICAL EXAMINER. GIVE PAGES 271, 272, AND 273 TO THE FUNERAL DIRECTOR. GIVE PAGES 274, 275, AND 276 TO THE MEDICAL EXAMINER. GIVE PAGES 277, 278, AND 279 TO THE FUNERAL DIRECTOR. GIVE PAGES 280, 281, AND 282 TO THE MEDICAL EXAMINER. GIVE PAGES 283, 284, AND 285 TO THE FUNERAL DIRECTOR. GIVE PAGES 286, 287, AND 288 TO THE MEDICAL EXAMINER. GIVE PAGES 289, 290, AND 291 TO THE FUNERAL DIRECTOR. GIVE PAGES 292, 293, AND 294 TO THE MEDICAL EXAMINER. GIVE PAGES 295, 296, AND 297 TO THE FUNERAL DIRECTOR. GIVE PAGES 298, 299, AND 300 TO THE MEDICAL EXAMINER. GIVE PAGES 301, 302, AND 303 TO THE FUNERAL DIRECTOR. GIVE PAGES 304, 305, AND 306 TO THE MEDICAL EXAMINER. GIVE PAGES 307, 308, AND 309 TO THE FUNERAL DIRECTOR. GIVE PAGES 310, 311, AND 312 TO THE MEDICAL EXAMINER. GIVE PAGES 313, 314, AND 315 TO THE FUNERAL DIRECTOR. GIVE PAGES 316, 317, AND 318 TO THE MEDICAL EXAMINER. GIVE PAGES 319, 320, AND 321 TO THE FUNERAL DIRECTOR. GIVE PAGES 322, 323, AND 324 TO THE MEDICAL EXAMINER. GIVE PAGES 325, 326, AND 327 TO THE FUNERAL DIRECTOR. GIVE PAGES 328, 329, AND 330 TO THE MEDICAL EXAMINER. GIVE PAGES 331, 332, AND 333 TO THE FUNERAL DIRECTOR. GIVE PAGES 334, 335, AND 336 TO THE MEDICAL EXAMINER. GIVE PAGES 337, 338, AND 339 TO THE FUNERAL DIRECTOR. GIVE PAGES 340, 341, AND 342 TO THE MEDICAL EXAMINER. GIVE PAGES 343, 344, AND 345 TO THE FUNERAL DIRECTOR. GIVE PAGES 346, 347, AND 348 TO THE MEDICAL EXAMINER. GIVE PAGES 349, 350, AND 351 TO THE FUNERAL DIRECTOR. GIVE PAGES 352, 353, AND 354 TO THE MEDICAL EXAMINER. GIVE PAGES 355, 356, AND 357 TO THE FUNERAL DIRECTOR. GIVE PAGES 358, 359, AND 360 TO THE MEDICAL EXAMINER. GIVE PAGES 361, 362, AND 363 TO THE FUNERAL DIRECTOR. GIVE PAGES 364, 365, AND 366 TO THE MEDICAL EXAMINER. GIVE PAGES 367, 368, AND 369 TO THE FUNERAL DIRECTOR. GIVE PAGES 370, 371, AND 372 TO THE MEDICAL EXAMINER. GIVE PAGES 373, 374, AND 375 TO THE FUNERAL DIRECTOR. GIVE PAGES 376, 377, AND 378 TO THE MEDICAL EXAMINER. GIVE PAGES 379, 380, AND 381 TO THE FUNERAL DIRECTOR. GIVE PAGES 382, 383, AND 384 TO THE MEDICAL EXAMINER. GIVE PAGES 385, 386, AND 387 TO THE FUNERAL DIRECTOR. GIVE PAGES 388, 389, AND 390 TO THE MEDICAL EXAMINER. GIVE PAGES 391, 392, AND 393 TO THE FUNERAL DIRECTOR. GIVE PAGES 394, 395, AND 396 TO THE MEDICAL EXAMINER. GIVE PAGES 397, 398, AND 399 TO THE FUNERAL DIRECTOR. GIVE PAGES 400, 401, AND 402 TO THE MEDICAL EXAMINER. GIVE PAGES 403, 404, AND 405 TO THE FUNERAL DIRECTOR. GIVE PAGES 406, 407, AND 408 TO THE MEDICAL EXAMINER. GIVE PAGES 409, 410, AND 411 TO THE FUNERAL DIRECTOR. GIVE PAGES 412, 413, AND 414 TO THE MEDICAL EXAMINER. GIVE PAGES 415, 416, AND 417 TO THE FUNERAL DIRECTOR. GIVE PAGES 418, 419, AND 420 TO THE MEDICAL EXAMINER. GIVE PAGES 421, 422, AND 423 TO THE FUNERAL DIRECTOR. GIVE PAGES 424, 425, AND 426 TO THE MEDICAL EXAMINER. GIVE PAGES 427, 428, AND 429 TO THE FUNERAL DIRECTOR. GIVE PAGES 430, 431, AND 432 TO THE MEDICAL EXAMINER. GIVE PAGES 433, 434, AND 435 TO THE FUNERAL DIRECTOR. GIVE PAGES 436, 437, AND 438 TO THE MEDICAL EXAMINER. GIVE PAGES 439, 440, AND 441 TO THE FUNERAL DIRECTOR. GIVE PAGES 442, 443, AND 444 TO THE MEDICAL EXAMINER. GIVE PAGES 445, 446, AND 447 TO THE FUNERAL DIRECTOR. GIVE PAGES 448, 449, AND 450 TO THE MEDICAL EXAMINER. GIVE PAGES 451, 452, AND 453 TO THE FUNERAL DIRECTOR. GIVE PAGES 454, 455, AND 456 TO THE MEDICAL EXAMINER. GIVE PAGES 457, 458, AND 459 TO THE FUNERAL DIRECTOR. GIVE PAGES 460, 461, AND 462 TO THE MEDICAL EXAMINER. GIVE PAGES 463, 464, AND 465 TO THE FUNERAL DIRECTOR. GIVE PAGES 466, 467, AND 468 TO THE MEDICAL EXAMINER. GIVE PAGES 469, 470, AND 471 TO THE FUNERAL DIRECTOR. GIVE PAGES 472, 473, AND 474 TO THE MEDICAL EXAMINER. GIVE PAGES 475, 476, AND 477 TO THE FUNERAL DIRECTOR. GIVE PAGES 478, 479, AND 480 TO THE MEDICAL EXAMINER. GIVE PAGES 481, 482, AND 483 TO THE FUNERAL DIRECTOR. GIVE PAGES 484, 485, AND 486 TO THE MEDICAL EXAMINER. GIVE PAGES 487, 488, AND 489 TO THE FUNERAL DIRECTOR. GIVE PAGES 490, 491, AND 492 TO THE MEDICAL EXAMINER. GIVE PAGES 493, 494, AND 495 TO THE FUNERAL DIRECTOR. GIVE PAGES 496, 497, AND 498 TO THE MEDICAL EXAMINER. GIVE PAGES 499, 500, AND 501 TO THE FUNERAL DIRECTOR. GIVE PAGES 502, 503, AND 504 TO THE MEDICAL EXAMINER. GIVE PAGES 505, 506, AND 507 TO THE FUNERAL DIRECTOR. GIVE PAGES 508, 509, AND 510 TO THE MEDICAL EXAMINER. GIVE PAGES 511, 512, AND 513 TO THE FUNERAL DIRECTOR. GIVE PAGES 514, 515, AND 516 TO THE MEDICAL EXAMINER. GIVE PAGES 517, 518, AND 519 TO THE FUNERAL DIRECTOR. GIVE PAGES 520, 521, AND 522 TO THE MEDICAL EXAMINER. GIVE PAGES 523, 524, AND 525 TO THE FUNERAL DIRECTOR. GIVE PAGES 526, 527, AND 528 TO THE MEDICAL EXAMINER. GIVE PAGES 529, 530, AND 531 TO THE FUNERAL DIRECTOR. GIVE PAGES 532, 533, AND 534 TO THE MEDICAL EXAMINER. GIVE PAGES 535, 536, AND 537 TO THE FUNERAL DIRECTOR. GIVE PAGES 538, 539, AND 540 TO THE MEDICAL EXAMINER. GIVE PAGES 541, 542, AND 543 TO THE FUNERAL DIRECTOR. GIVE PAGES 544, 545, AND 546 TO THE MEDICAL EXAMINER. GIVE PAGES 547, 548, AND 549 TO THE FUNERAL DIRECTOR. GIVE PAGES 550, 551, AND 552 TO THE MEDICAL EXAMINER. GIVE PAGES 553, 554, AND 555 TO THE FUNERAL DIRECTOR. GIVE PAGES 556, 557, AND 558 TO THE MEDICAL EXAMINER. GIVE PAGES 559, 560, AND 561 TO THE FUNERAL DIRECTOR. GIVE PAGES 562, 563, AND 564 TO THE MEDICAL EXAMINER. GIVE PAGES 565, 566, AND 567 TO THE FUNERAL DIRECTOR. GIVE PAGES 568, 569, AND 570 TO THE MEDICAL EXAMINER. GIVE PAGES 571, 572, AND 573 TO THE FUNERAL DIRECTOR. GIVE PAGES 574, 575, AND 576 TO THE MEDICAL EXAMINER. GIVE PAGES 577, 578, AND 579 TO THE FUNERAL DIRECTOR. GIVE PAGES 580, 581, AND 582 TO THE MEDICAL EXAMINER. GIVE PAGES 583, 584, AND 585 TO THE FUNERAL DIRECTOR. GIVE PAGES 586, 587, AND 588 TO THE MEDICAL EXAMINER. GIVE PAGES 589, 590, AND 591 TO THE FUNERAL DIRECTOR. GIVE PAGES 592, 593, AND 594 TO THE MEDICAL EXAMINER. GIVE PAGES 595, 596, AND 597 TO THE FUNERAL DIRECTOR. GIVE PAGES 598, 599, AND 600 TO THE MEDICAL EXAMINER. GIVE PAGES 601, 602, AND 603 TO THE FUNERAL DIRECTOR. GIVE PAGES 604, 605, AND 606 TO THE MEDICAL EXAMINER. GIVE PAGES 607, 608, AND 609 TO THE FUNERAL DIRECTOR. GIVE PAGES 610, 611, AND 612 TO THE MEDICAL EXAMINER. GIVE PAGES 613, 614, AND 615 TO THE FUNERAL DIRECTOR. GIVE PAGES 616, 617, AND 618 TO THE MEDICAL EXAMINER. GIVE PAGES 619, 620, AND 621 TO THE FUNERAL DIRECTOR. GIVE PAGES 622, 623, AND 624 TO THE MEDICAL EXAMINER. GIVE PAGES 625, 626, AND 627 TO THE FUNERAL DIRECTOR. GIVE PAGES 628, 629, AND 630 TO THE MEDICAL EXAMINER. GIVE PAGES 631, 632, AND 633 TO THE FUNERAL DIRECTOR. GIVE PAGES 634, 635, AND 636 TO THE MEDICAL EXAMINER. GIVE PAGES 637, 638, AND 639 TO THE FUNERAL DIRECTOR. GIVE PAGES 640, 641, AND 642 TO THE MEDICAL EXAMINER. GIVE PAGES 643, 644, AND 645 TO THE FUNERAL DIRECTOR. GIVE PAGES 646, 647, AND 648 TO THE MEDICAL EXAMINER. GIVE PAGES 649, 650, AND 651 TO THE FUNERAL DIRECTOR. GIVE PAGES 652, 653, AND 654 TO THE MEDICAL EXAMINER. GIVE PAGES 655, 656, AND 657 TO THE FUNERAL DIRECTOR. GIVE PAGES 658, 659, AND 660 TO THE MEDICAL EXAMINER. GIVE PAGES 661, 662, AND 663 TO THE FUNERAL DIRECTOR. GIVE PAGES 664, 665, AND 666 TO THE MEDICAL EXAMINER. GIVE PAGES 667, 668, AND 669 TO THE FUNERAL DIRECTOR. GIVE PAGES 670, 671, AND 672 TO THE MEDICAL EXAMINER. GIVE PAGES 673, 674, AND 675 TO THE FUNERAL DIRECTOR. GIVE PAGES 676, 677, AND 678 TO THE MEDICAL EXAMINER. GIVE PAGES 679, 680, AND 681 TO THE FUNERAL DIRECTOR. GIVE PAGES 682, 683, AND 684 TO THE MEDICAL EXAMINER. GIVE PAGES 685, 686, AND 687 TO THE FUNERAL DIRECTOR. GIVE PAGES 688, 689, AND 690 TO THE MEDICAL EXAMINER. GIVE PAGES 691, 692, AND 693 TO THE FUNERAL DIRECTOR. GIVE PAGES 694, 695, AND 696 TO THE MEDICAL EXAMINER. GIVE PAGES 697, 698, AND 699 TO THE FUNERAL DIRECTOR. GIVE PAGES 700, 701, AND 702 TO THE MEDICAL EXAMINER. GIVE PAGES 703, 704, AND 705 TO THE FUNERAL DIRECTOR. GIVE PAGES 706, 707, AND 708 TO THE MEDICAL EXAMINER. GIVE PAGES 709, 710, AND 711 TO THE FUNERAL DIRECTOR. GIVE PAGES 712, 713, AND 714 TO THE MEDICAL EXAMINER. GIVE PAGES 715, 716, AND 717 TO THE FUNERAL DIRECTOR. GIVE PAGES 718, 719, AND 720 TO THE MEDICAL EXAMINER. GIVE PAGES 721, 722, AND 723 TO THE FUNERAL DIRECTOR. GIVE PAGES 724, 725, AND 726 TO THE MEDICAL EXAMINER. GIVE PAGES 727, 728, AND 729 TO THE FUNERAL DIRECTOR. GIVE PAGES 730, 731, AND 732 TO THE MEDICAL EXAMINER. GIVE PAGES 733, 734, AND 735 TO THE FUNERAL DIRECTOR. GIVE PAGES 736, 737, AND 738 TO THE MEDICAL EXAMINER. GIVE PAGES 739, 740, AND 741 TO THE FUNERAL DIRECTOR. GIVE PAGES 742, 743, AND 744 TO THE MEDICAL EXAMINER. GIVE PAGES 745, 746, AND 747 TO THE FUNERAL DIRECTOR. GIVE PAGES 748, 749, AND 750 TO THE MEDICAL EXAMINER. GIVE PAGES 751, 752, AND 753 TO THE FUNERAL DIRECTOR. GIVE PAGES 754, 755, AND 756 TO THE MEDICAL EXAMINER. GIVE PAGES 757, 758, AND 759 TO THE FUNERAL DIRECTOR. GIVE PAGES 760, 761, AND 762 TO THE MEDICAL EXAMINER. GIVE PAGES 763, 764, AND 765 TO THE FUNERAL DIRECTOR. GIVE PAGES 766, 767, AND 768 TO THE MEDICAL EXAMINER. GIVE PAGES 769, 770, AND 771 TO THE FUNERAL DIRECTOR. GIVE PAGES 772, 773, AND 774 TO THE MEDICAL EXAMINER. GIVE PAGES 775, 776, AND 777 TO THE FUNERAL DIRECTOR. GIVE PAGES 778, 779, AND 780 TO THE MEDICAL EXAMINER. GIVE PAGES 781, 782, AND 783 TO THE FUNERAL DIRECTOR. GIVE PAGES 784, 785, AND 786 TO THE MEDICAL EXAMINER. GIVE PAGES 787, 788, AND 789 TO THE FUNERAL DIRECTOR. GIVE PAGES 790, 791, AND 792 TO THE MEDICAL EXAMINER. GIVE PAGES 793, 794, AND 795 TO THE FUNERAL DIRECTOR. GIVE PAGES 796, 797, AND 798 TO THE MEDICAL EXAMINER. GIVE PAGES 799, 800, AND 801 TO THE FUNERAL DIRECTOR. GIVE PAGES 802, 803, AND 804 TO THE MEDICAL EXAMINER. GIVE PAGES 805, 806, AND 807 TO THE FUNERAL DIRECTOR. GIVE PAGES 808, 809, AND 810 TO THE MEDICAL EXAMINER. GIVE PAGES 811, 812, AND 813 TO THE FUNERAL DIRECTOR. GIVE PAGES 814, 815, AND 816 TO THE MEDICAL EXAMINER. GIVE PAGES 817, 818, AND 819 TO THE FUNERAL DIRECTOR. GIVE PAGES 820, 821, AND 822 TO THE MEDICAL EXAMINER. GIVE PAGES 823, 824, AND 825 TO THE FUNERAL DIRECTOR. GIVE PAGES 826, 827, AND 828 TO THE MEDICAL EXAMINER. GIVE PAGES 829, 830, AND 831 TO THE FUNERAL DIRECTOR. GIVE PAGES 832, 833, AND 834 TO THE MEDICAL EXAMINER. GIVE PAGES 835, 836, AND 837 TO THE FUNERAL DIRECTOR. GIVE PAGES 838, 839, AND 840 TO THE MEDICAL EXAMINER. GIVE PAGES 841, 842, AND 843 TO THE FUNERAL DIRECTOR. GIVE PAGES 844, 845, AND 846 TO THE MEDICAL EXAMINER. GIVE PAGES 847, 848, AND 849 TO THE FUNERAL DIRECTOR. GIVE PAGES 850, 851, AND 852 TO THE MEDICAL EXAMINER. GIVE PAGES 853, 854, AND 855 TO THE FUNERAL DIRECTOR. GIVE PAGES 856, 857, AND 858 TO THE MEDICAL EXAMINER. 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GIVE PAGES 913, 914, AND 915 TO THE FUNERAL DIRECTOR. GIVE PAGES 916, 917, AND 918 TO THE MEDICAL EXAMINER. GIVE PAGES 919, 920, AND 921 TO THE FUNERAL DIRECTOR. GIVE PAGES 922, 923, AND 924 TO THE MEDICAL EXAMINER. GIVE PAGES 925, 926, AND 927 TO THE FUNERAL DIRECTOR. GIVE PAGES 928, 929, AND 930 TO THE MEDICAL EXAMINER. GIVE PAGES 931, 932, AND 933 TO THE FUNERAL DIRECTOR. GIVE PAGES 934, 935, AND 936 TO THE MEDICAL EXAMINER. GIVE PAGES 937, 938, AND 939 TO THE FUNERAL DIRECTOR. GIVE PAGES 940, 941, AND 942 TO THE MEDICAL EXAMINER. GIVE PAGES 943, 944, AND 945 TO THE FUNERAL DIRECTOR. GIVE PAGES 946, 947, AND 948 TO THE MEDICAL EXAMINER. GIVE PAGES 949, 950, AND 951 TO THE FUNERAL DIRECTOR. GIVE PAGES 952, 953, AND 954 TO THE MEDICAL EXAMINER. GIVE PAGES 955, 956, AND 957 TO THE FUNERAL DIRECTOR. GIVE PAGES 958, 959, AND 960 TO THE MEDICAL EXAMINER. GIVE PAGES 961, 962, AND 963 TO THE FUNERAL DIRECTOR. GIVE PAGES 964, 965, AND 966 TO THE MEDICAL EXAMINER. 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BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Hugh T. Duffy

2a. DATE KNOWN
OF
DEATH
MATED

Dec 20 1982 7:25 PM

3 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE
PRONOUNCED
DEAD

Dec 20 1982 7:25 PM

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery MD.

10. CITY OR TOWN OF DEATH

S. T. Spg

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Holy Cross Hosp

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Retired

12b. KIND OF BUSINESS
OR INDUSTRY

Teacher

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE 13b. CITY OR TOWN 13c. CITY OR TOWN

Md Mont Spg

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

2237 Glen Allen Ave

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Hugh

Duffy Sr.

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Mary

Murphy

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

201-14-2863

17. INFORMANT

Linda Duffy

ADDRESS

2237 Glen Allen Ave #201
Silver Spring, Md. 20906

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

4291

IMMEDIATE CAUSE (a)

Acute Myocardial Disi

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) Chronic Myocardial Disi

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

None

19a. DATE OF OPERATION

None

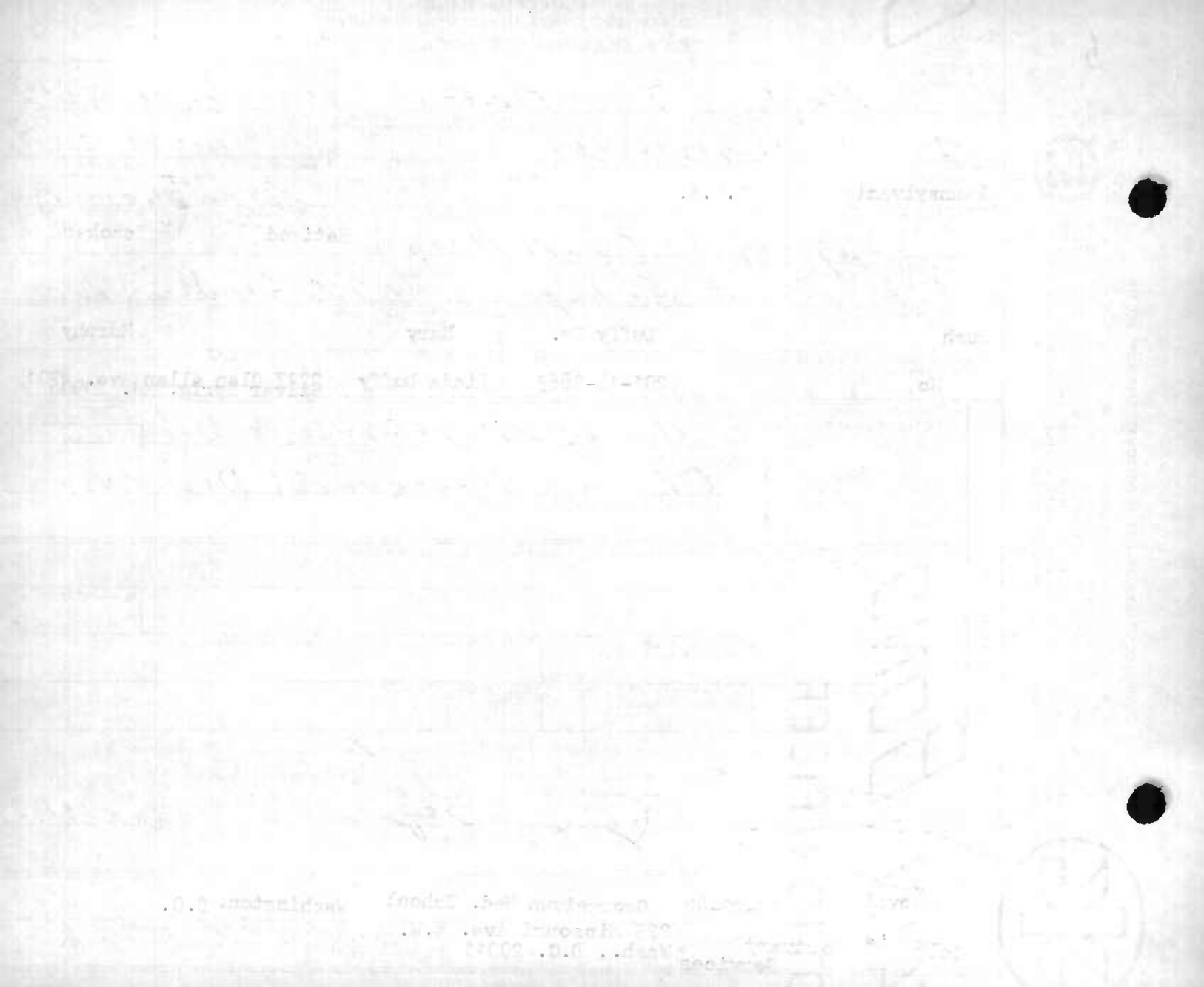
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

None

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CA



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 2 5 5 4
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last LULA V. DUSTIN			2a. DATE OF DEATH 12 Month 19 Day 82 Year		2b. HOUR 4 P.M.
3. SEX Female	4. RACE White		5. DATE OF BIRTH March 20, 1905		6. AGE (In years last birthday) 77 YRS.
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 800 Orchard Way		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland		COUNTY Montgomery	13c. CITY OR TOWN Silver Spring		13e. STREET AND NUMBER 800 Orchard Way
14. FATHER'S NAME First Middle Last Ambrose Lucian Murray			15. MOTHER'S MAIDEN NAME First Middle Last Carrie Esther Leathers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown N/A		16b. SOCIAL SECURITY NO. 218-50-7345		17. INFORMANT Ronald B. Dustin-son-Middletown, Md. 21769	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Cardiac Failure, C.H.D. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma Breast					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 11/16/81 , 19 81 , to 12/19/82 , that (I) (we) last saw the deceased alive on 11/23/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/20/82	
22d. PHYSICIAN'S NAME (Type) VIVEK C VAID M.D.		22e. ADDRESS 7676 NEW HAMPSHIRE AVE., HYATTSVILLE, MD. 20783			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-22-1982		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
				23d. LOCATION (City or Town) (County) (State) Burtonsville Montgomery Md.	
24. FUNERAL DIRECTOR HINES/RINALDI		ADDRESS 11800 NEW HAMPSHIRE AVE.		25a. REC'D BY REGISTRAR DEC 21 1982	
				25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY
1301 EAST 58TH STREET
CHICAGO, ILL. 60637
TEL. 733-4331

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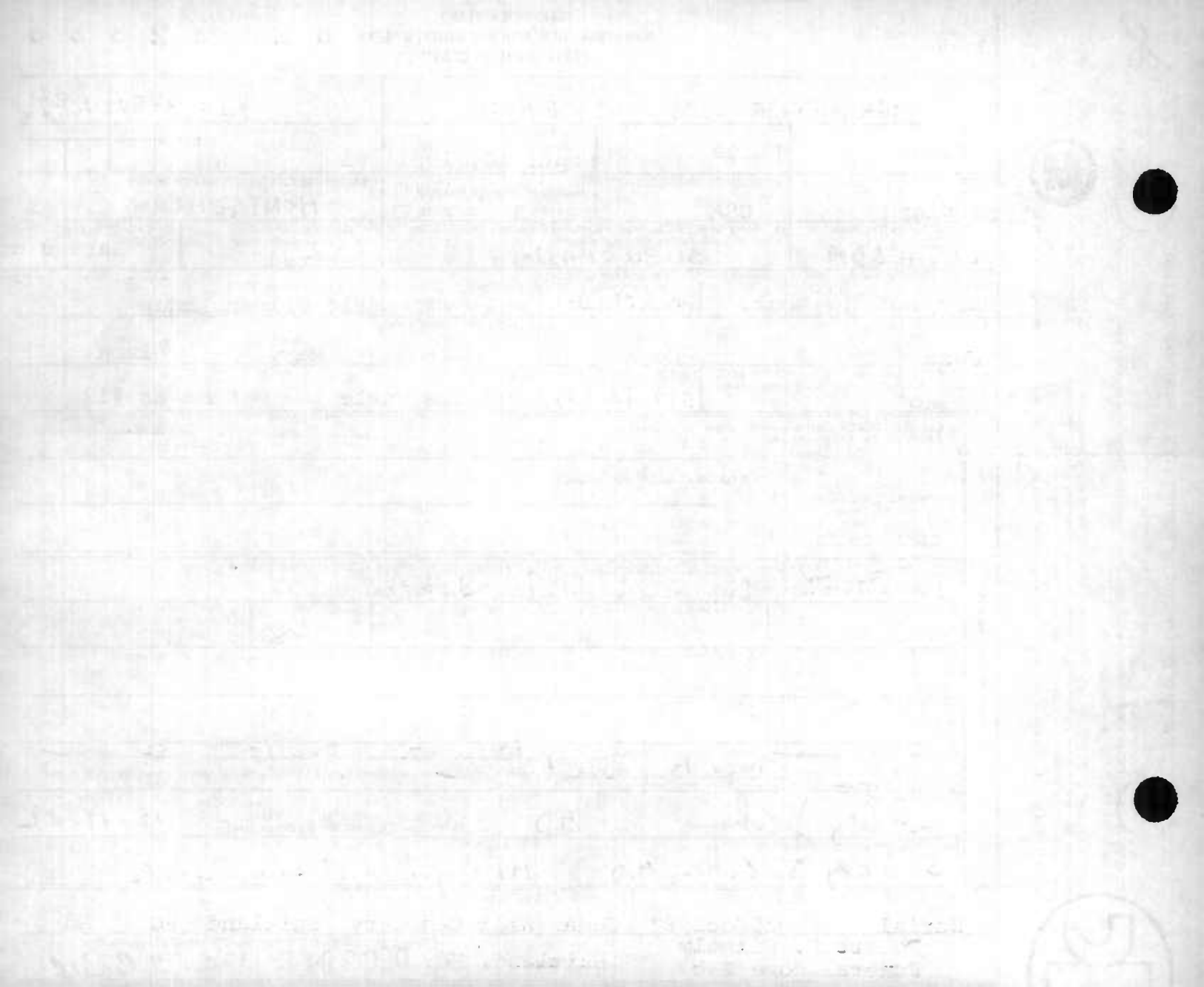
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 5 5 5	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) MARGUERITE M EARLE					2a. DATE OF DEATH MONTH DAY YEAR 12-13-82					2b. HOUR 1:57 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Bureau of Pmt and Engr		
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6814 Tilden Lane			
14. FATHER'S NAME FIRST MIDDLE LAST John Cook					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Mary Dixon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-48-0088		17. INFORMANT ADDRESS William Unkle				Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Poor nutrition, Bone marrow exhaustion, diabetes.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from July 23, 1976 to Dec 13, 1982 , that (I) met lost saw the deceased alive on Dec 12, 1982 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death.											
22b. SIGNATURE Sidney J. Cohen M.D. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 12-13-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Cohen, M.D.				22e. ADDRESS 121 Congressional Lane, Rockville							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 15 Dec 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md			
24. FUNERAL HOME NAME Robert E. Wilhelm Funeral Home Inc				25a. DATE REC'D. BY REGISTRAR DEC 22 1982				25b. REGISTRAR'S SIGNATURE John J. Canfield			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 5 6

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			MONTH DAY YEAR			MONTHS DAYS HOURS MIN.		
Immaculate Rose C. Obernolte			Dec. 25 1982			4:00 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	Caucasian	MONTH DAY YEAR	76 YRS			MONTHS DAYS HOURS MIN.		
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania	United States		Montgomery MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda	Suburban Hospital	Homemaker	Home					
13a. STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS			zip: 15221		
Pennsylvania	Allegheny	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	709 Pitt Street					
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST	FIRST MIDDLE LAST							
Phillip	Pepe	Maria Not Available						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT						
NO	190-10-5429D	Richard C. Stafford (Son) #1						
		Bracknell Circle, Rockville, Md. 20850						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) NON-HODGKINS LYMPHOMA								7 YRS
DUE TO, OR AS A CONSEQUENCE OF (b)								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR						
		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-14, 1982, to 12-25, 1982, that (I) (we) lost								
saw the deceased alive on 12-25, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		22c. DATE SIGNED				
Richard H. Power, MD		MD		12/25/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
Richard H. Power, MD		10800 Connecticut Ave, Kensington, MD						
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		December 28, 1982		Mt. Carmel Cemetery		CITY OR TOWN COUNTY STATE		
						Penn Hills, Allegheny, Pa.		
24. FUNERAL DIRECTOR				24a. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE		
Robert A. Pumphrey Funeral Homes, P.A.				DEC 29 1982		John J. Carver		
7557 Wisconsin Avenue, Bethesda, Maryland								

MEDICAL CERTIFICATION

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of the University of California



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 5 7

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAM EIG			2a. DATE OF DEATH MONTH DAY YEAR Dec. 25, 1982		2b. HOUR 10:50 AM			
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9701 Fields Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Developer		12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Eig				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-30-3516		17. INFORMANT Dr. Blaine Eig; 9701 Fields Road				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

1629 IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from **Dec. 22, 1982** to **Dec. 22, 1982**, that (I) (we) last saw the deceased alive on **Dec. 22, 1982**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

12-25-82

STEPHEN N. JONES, M.D.

809 Viers Mill Road; Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial23b. DATE
12-27-8223c. NAME OF CEMETERY OR CREMATORY
Judean Memorial Gardens23d. LOCATION
CITY OR TOWN COUNTY STATE
Olney, Montgomery, Maryland24. FUNERAL DIRECTOR
NAME

ADDRESS

Rockville, Md.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Danzansky-Goldberg Chapels; 1170 Rockville Pike

DEC 28 1982

John J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3

100

DATE	DESCRIPTION	AMOUNT	REMARKS
10/1/50
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10/4/50
10/5/50
10/6/50
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10/30/50
10/31/50




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 5 5 8 REG. NO.				
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) WILSON H. EIMER					2a. DATE OF DEATH MONTH DAY YEAR HOUR 12 3 82 120AM				
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 4 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.								
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinists		12b. KIND OF BUSINESS OR INDUSTRY Navy Yard						
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4005 Southend Road						
14. FATHER'S NAME FIRST MIDDLE LAST John F. Eimer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Bell Tolbert					ADDRESS Rockville, Md. 20853				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 231 62 2533		17. INFORMANT Wilson Donald Eimer (son) 4005 Southend Rd										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4379 IMMEDIATE CAUSE (a) Terminal cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) —										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —										
22a. I certify that (I) (this hospital) attended the deceased from November 1979 , 19 82 , to 12/4/82 , 19 82 , that (I) (we) last saw the deceased alive on November 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.														
22b. SIGNATURE 					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/3/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSOTH LEKAGUL, MD					22e. ADDRESS 7425 ARLINGTON RD, BETHESDA, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/6/82		23c. NAME OF CEMETERY OR CREMATORY West Alexander Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Alexander, Penna.						
24. FUNERAL DIRECTOR NAME ADDRESS Ives Funeral Home, Arlington, Virginia					25. DATE RECEIVED BY REGISTRAR DEC 7 1982									

MEDICAL CERTIFICATION



1/1/71

1/1/71

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1/1/71

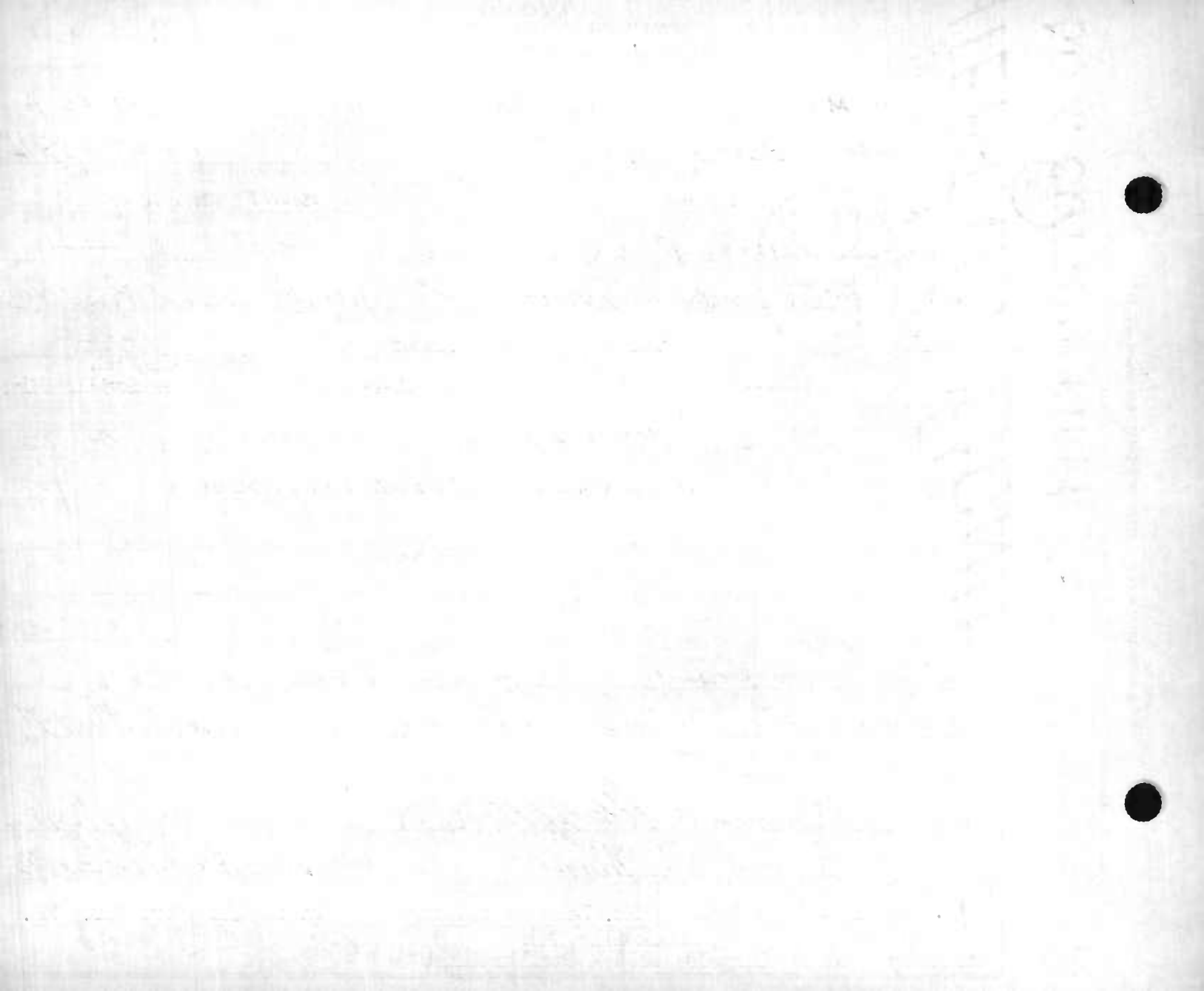
1/1/71

1/1/71

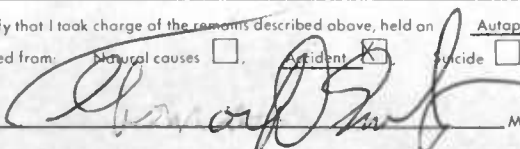
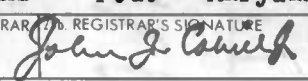
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 1772 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 5 5 9									
1. DECEASED NAME (TYPE OR PRINT) HOMA ELEYAHOUZADEH										2a. DATE KNOWN OF DEATH 12 24 82		2b. HOUR AM							
3. SEX Fe		4. RACE Cauc		5. DATE OF BIRTH Unknown- 1939		6. AGE (IN YEARS) 42		7. IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD 12 24 1982		2d. HOUR 8:10 AM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRAN				7b. CITIZEN OF WHAT COUNTRY? IRAN				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY		MD.					
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11801 Rockville Pike				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None				12b. KIND OF BUSINESS OR INDUSTRY -----							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE MD				13b. COUNTY MONT GOMERY				13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11501 Rockville Pike 1403	
14. FATHER'S NAME FIRST Moishe MIDDLE LAST Yadidi				15. MOTHER'S MAIDEN NAME FIRST Miriam MIDDLE LAST Cohen															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. None				17. INFORMANT Rockville, Md. Saeed Eleyahouzadeh; 11801 Rockville Pike											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) CORONARY ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) 1 yr										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION ---				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? ---								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Found Dead in Bed				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Found 12/21/82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET 11801 Rockville Pike CITY OR TOWN Rockville COUNTY Montgomery STATE MD											
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Francis C Mayle M.D. (SPECIFY)										MEDICAL EXAMINER				DATE SIGNED 12/24/82					
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C Mayle										ADDRESS 8200 Wisconsin Ave Bethesda MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-26-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery				23d. LOCATION CITY OR TOWN Hyattsville, Pr. Geo. COUNTY MD. STATE Md.									
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike ADDRESS Rockville, Md.										25a. DATE REC'D. BY REGISTRAR DEC 29 1982				25b. REGISTRAR'S SIGNATURE John J. Smith					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 3 2 5 6 0	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Romana Elvira Elliott										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 11 19 82	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1924	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 58	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 11 19 82		2d. HOUR 3:47 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady		12b. KIND OF BUSINESS INDUSTRY Services, Inc.			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Md. 20783 Prince Geo. Hyattsville										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 38 2992		17. INFORMANT Denise Elliott		17a. ADDRESS 8258 Canning Terrace Greenbelt, Md. 20770					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Cranio cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:40 P.M. 12 11 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9000 Blk. Riggs Rd, Adelphi, Mont. Co., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER						DATE SIGNED 12/12/82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Balto, Md.									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/17/82		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi P.G. Maryland					
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR DEC 21 1982					
						25b. REGISTRAR'S SIGNATURE 					

Serial 12/17/82 George Washington Co. - Wheeling, W. Va. - Maryland
Francis Macdonald's Sons Funeral Home, Inc.
Hollywood, Maryland

No. 20783 Prince Geo. Hyattsville
217 BR 2002 Denise Elliott Greenbelt, Md. 20770
2228 Cananda Terrace
Unknown

No. 20783 Prince Geo. Hyattsville x 1907 Erie Street Apt 204
Baltimore, Md. x
Italy

Serial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 6 1			
1. FOR STATE REGISTRAR <i>George F.</i>				REG. NO.			
1. DECEASED NAME FIRST MIDDLE LAST <i>George F. Elmendorf</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>12 31 82</i>		2b. HOUR <i>12 20 PM</i>	
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 4 12</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wisconsin</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Electrician - PEPCO</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>		13b. CITY OR TOWN <i>Pr. Geo. Hyattsville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3120-Madison St. (20782)</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Arthur Elmendorf</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bessie Bul</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWII</i>		17. INFORMANT <i>Ronald Brightwell-</i>		ADDRESS <i>10 Bay Wood Court Palm Harbor, Fla.</i>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>1991</i> IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Adenocarcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>6 weeks</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>11/25</i> <i>82</i> to <i>12/31</i> <i>82</i> , that (1) (we) last saw the deceased alive on <i>12/31</i> <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Thomas A. Bensinger</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		22c. DATE SIGNED <i>1/1/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thomas A. Bensinger</i>				22e. ADDRESS <i>7676 New Hampshire Ave Langley Park Md</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/4/1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Pr. Geo. Md. 20783</i>	
24. FUNERAL DIRECTOR NAME <i>Nalley's F.H. Inc.</i>				ADDRESS <i>Mt. Rainier, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 4 1983</i>	
				25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 6 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY ^{FIRST} J. ^{MIDDLE} EMERSON ^{LAST}		2a. DATE OF DEATH MONTH DAY YEAR 12-15-82 2b. HOUR 250P M.	
3 SEX Female	4 RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR September 16 1889	6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10 CITY OR TOWN OF DEATH Silver Springs	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Althea Woodland Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Howard Keats James	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hamilton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Mrs. Jack M. Cotton 5320 Carvel Road, Bethesda, Md. 20816	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Post Cerebral Vascular Accident (b) OSTEO ARTHRITIS			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Bernard A. Fitzgerald M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12-15-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD	22e. ADDRESS 217 UNIVERSITY BLVD E, SILVER SPRING MD 20901		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Dec 16, 82	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.
24. FUNERAL DIRECTOR NAME Wayne J. F. [Signature] ADDRESS Demaine Funeral Homes, Inc., Alex., Va. 22314		25a. DATE REC'D. BY REGISTRAR DEC 21 1982 REGISTRAR'S SIGNATURE [Signature]	

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1000-20 1000-20



[The following text is extremely faint and illegible, appearing as a series of horizontal lines across the page.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

3 2

5 6 3

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Baby Girl (Wilson) Estep		2a. DATE OF DEATH MONTH 11 DAY 14 YEAR 82		2b. HOUR 10:28 AM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH 11 DAY 14 YEAR 82		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 4 5 2	
7a. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Montg.	13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Richard MIDDLE Vernon LAST Estep, Jr.		15. MOTHER'S MAIDEN NAME FIRST Pearl MIDDLE Janice LAST Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac - Pulmonary Arrest 7599 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Macromic Pneumonia (c) Congenital Anomalies - quantifiable					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Shearin, M.D.		22b. ADDRESS 1811 Prince Philip Drive Olney, Maryland 20832		22c. DATE SIGNED DEC 27 1982	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
24. FUNERAL DIRECTOR NAME Montgomery General Hospital		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 27 1982	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

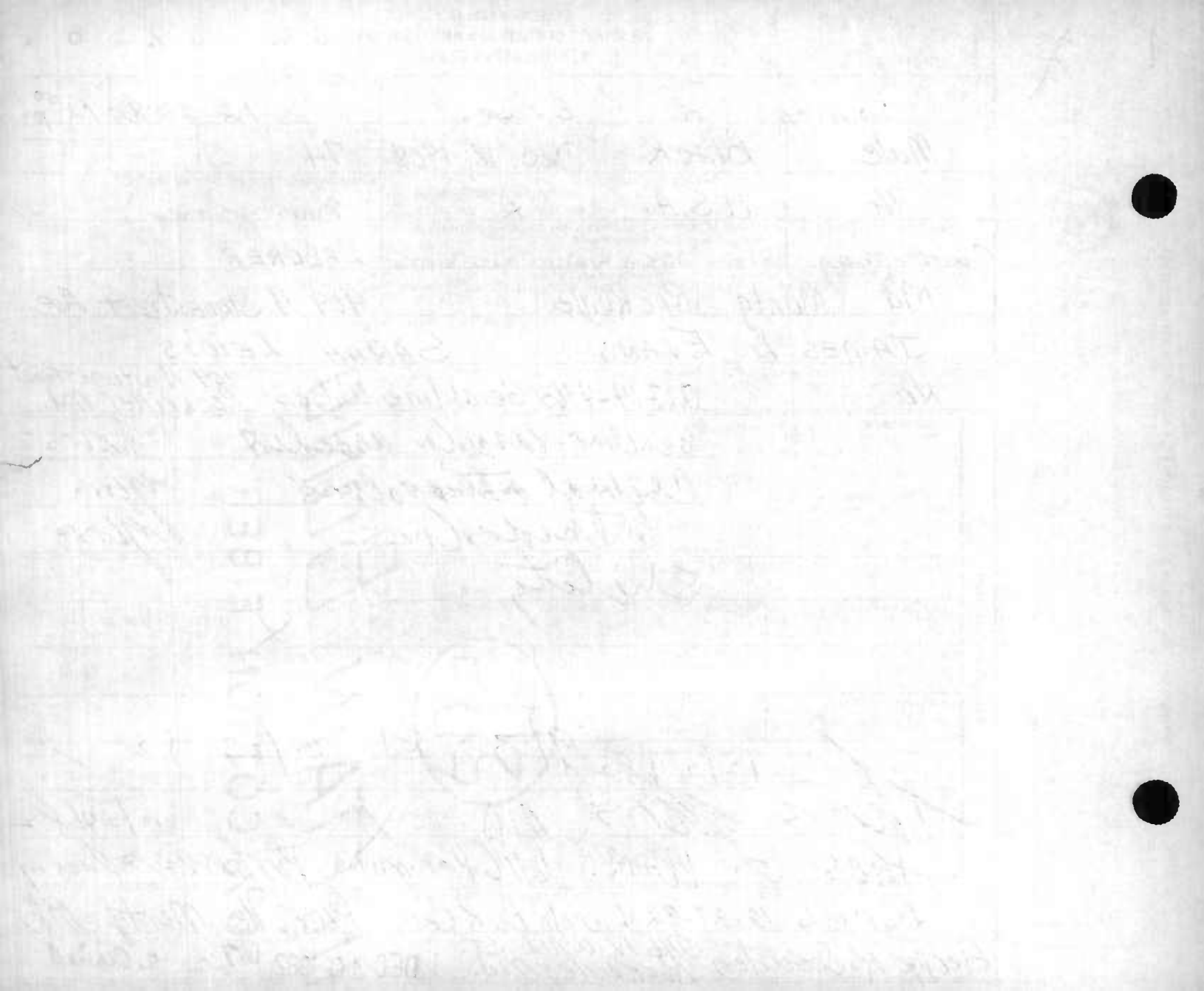
8 2 3 2 5 6 4

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) James B. Evans			2a. DATE OF DEATH MONTH DAY YEAR 12-23-82		2b. HOUR 13⁵⁰ PM	
3 SEX Male	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Dec. 18, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 74		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH Gaithersburg			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Herman Wilson Health Care Center			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STREET ADDRESS 909 N. Stonestreet Ave.			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES L. EVANS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH LEWIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 227-14-4363			
17. INFORMANT NAME ADDRESS Geraldine Wilson 909 N. Stonestreet Rockville Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Chronic arteriosclerosis (c) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Year 1 Year						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Shingles						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from 9/3 , 19 81 , to 12/23 , 19 82 , that (1) (b) lost saw the deceased alive on 12/23/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (c) (d) (did not view the body after death)						
22b. SIGNATURE THOS L. WARD MD				22c. DATE SIGNED 12/24/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOS L. WARD				22e. ADDRESS 616 Robinswood, Bethesda, 3/208/17		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-27-82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg Md.		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION		
24. FUNERAL DIRECTOR NAME George R. Snowden				25a. DATE REC'D BY REGISTRAR DEC 30 1982		
24b. ADDRESS 244 N. Wash. St. Rockville, Md.				25b. REGISTRAR'S SIGNATURE John J. Carver		

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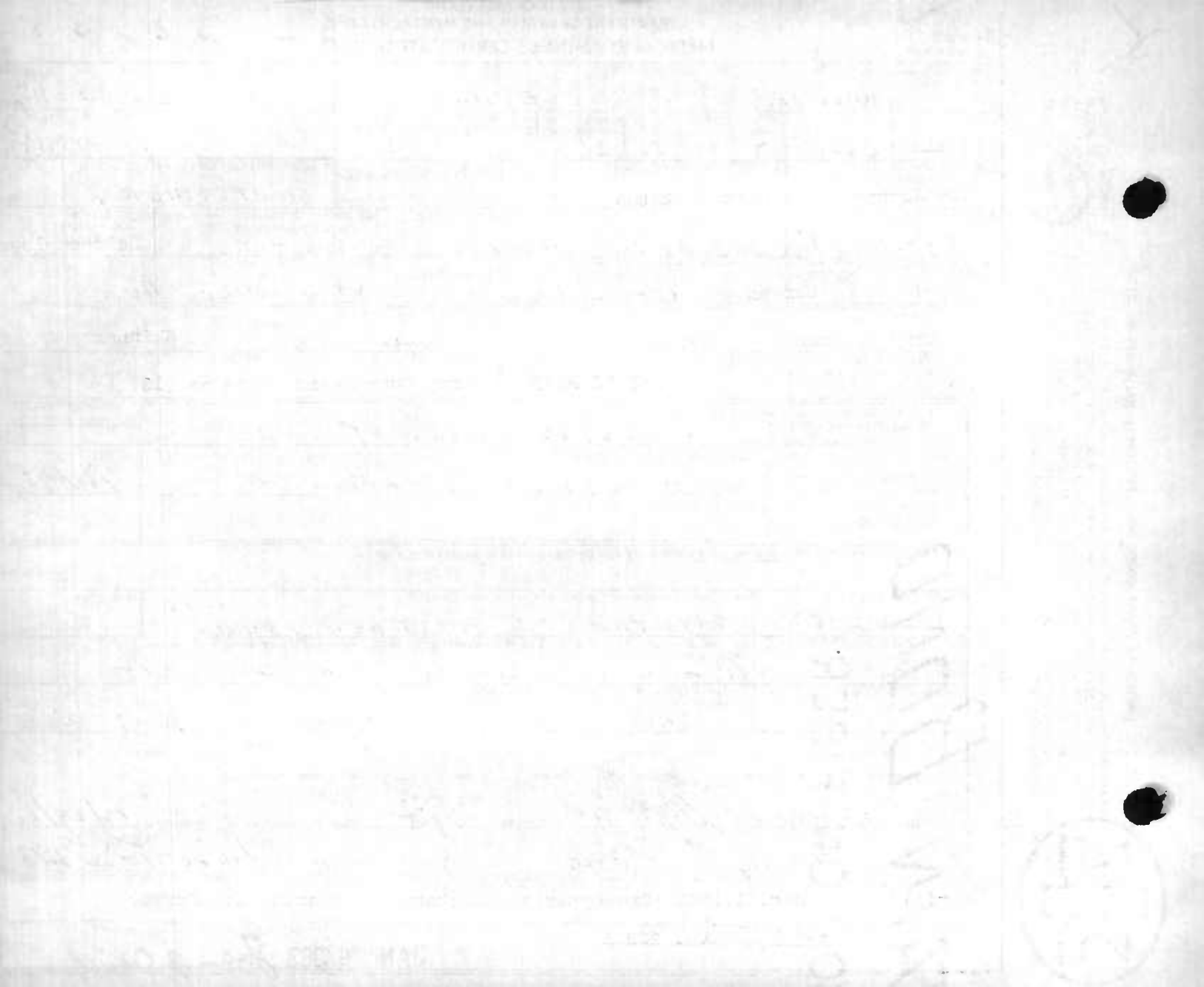


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 5 6 5	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM P EVANS										2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12 29 82	
3. SEX Male		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 7 19 56		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 26		7. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 29 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MINTCOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER			12b. KIND OF BUSINESS OR INDUSTRY Self-employed		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE N.J.			13b. CITY OR TOWN Bergen			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS 308 Woodside Ave		
14. FATHER'S NAME FIRST MIDDLE LAST Harry Gunn Evans					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Skinner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 157 38 8002		17. INFORMANT ADDRESS Harry Gunn Evans Same as #10				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>MULTIPLE TRAUMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 DAYS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10.											
19a. DATE OF OPERATION 12-22-82				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? LEFT FIXATION OF FRACTURED FEMUR						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 0100 PM 12 22 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) SINGLE CAR ACCIDENT					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET		21f. LOCATION STREET CLARKSBURG AVE		CITY OR TOWN MONT MD		STATE	
22a. I certify that I took charge of the remains described above, held or death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE Francis C Mayle Jr				TITLE (SPECIFY) M.D. DEPT				DATE SIGNED 12/24/82			
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE				ADDRESS 8200 Wisconsin Ave Bethesda MD							
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE Dec. 31, 1982		23c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Sparta, New Jersey		
24. FUNERAL DIRECTOR NAME Ives Funeral Home Arlington, Va. 22201						25a. DATE REC'D. BY REGISTRAR JAN 4 1983					
						25b. REGISTRAR'S SIGNATURE Joan E. Carver					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 5 6 6	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Alyce R. Eyster			2a. DATE OF DEATH December 4, 1982			2b. HOUR 9:40AM					
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 11 22 24		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COMPUTER ATTEND.		12b. KIND OF BUSINESS OR INDUSTRY DATA CENTER C+P			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12303 DOWNER XXXXXX		20906	
14. FATHER'S NAME FIRST MIDDLE LAST ELV C. EYSTER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLOTTE SHIPLEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 275-22-4238		17. INFORMANT ADDRESS JOSEPH EYSTER 104 MILLER AVE. MT. VERNON, OHIO					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Thrombocytopenia of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1539										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6 mo 1 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 11/10/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Caf of Colon - obstruc				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/4 , 19 82 , to 12/4 , 19 82 , that (I) (we) lost saw the deceased alive on 12/4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) move the body after death.											
22b. SIGNATURE C.H. Light		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/4/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.H. Light MD		22e. ADDRESS 18111 P & P Hwy Dr., Olney MD 2082									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE DEC. 4 1982		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VA.					
24. FUNERAL DIRECTOR FRANCIS J. COLLINS 500 UNIVERSITY BLVD. WEST SILVER SPRING, MD						25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 8 - 1982 John J. Canfield					

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WESTGOLDEN WASHINGTON

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HO 275-22-4234 JOSEPH EVSTER 104 MILLER AVE. MT. VERNON, OHIO

ALBANY, N.Y.
FEB. 2, 1982
METROPOLITAN CEN.
500 UNIVERSITY BLVD., WEST
SILVER SPRING, MD.

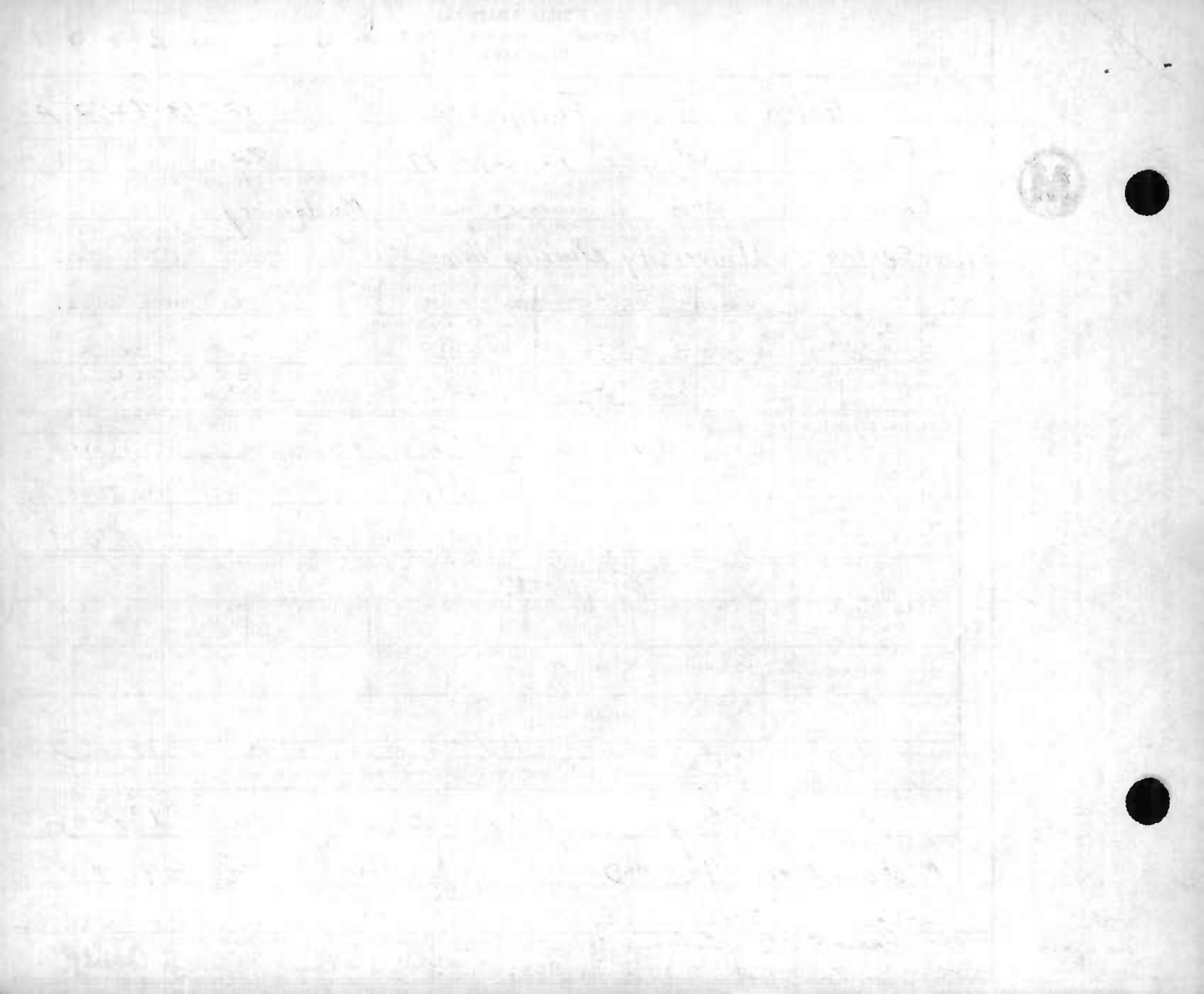
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 6 7 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Helen N. Fairgrieve</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>12-13-82</i>		2b. HOUR <i>2⁰⁰ A M</i>	
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12-27-99</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>82 YRS.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penn</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? <i>Md. Montgomery Bethesda X NO</i>				13e. STREET ADDRESS <i>9508 Seddon Court 20817</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Wickham Howard Neely</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ella K. Banks</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>155-36-1128</i>		17. INFORMANT <i>Jean S. Granum Bethesda, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4360 Urinary Tract Infection</i> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF <i>CVA</i> (b) DUE TO, OR AS A CONSEQUENCE OF <i>Hypertension</i> (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>6 months</i> <i>years</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Aspiration</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <i>Upper Montclair Essex N.J.</i>			
22a. I certify that (I) (the hospital) attended the deceased from <i>6/22</i> 19 <i>82</i> to <i>12/13</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>12/13</i> 19 <i>82</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>13 Dec</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael Liebowitz, MD</i>				22e. ADDRESS <i>1120 N H Ave S, Md 20904</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/17/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Hebron Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>P.O. Box 7428 Sil. Spr., Md.</i>		25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <i>DEC 16 1982 [Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 3 2 5 6 8	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		REG. NO.	
FIRST MIDDLE LAST CLINTON (NMN) FALCONER		MONTH DAY YEAR December 25, 1982		2b. HOUR 1:56 P_M	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR July 31, 1941		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jamaica, BWI	7b. CITIZEN OF WHAT COUNTRY? BWI	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH Clinical Center, Bethesda, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Aircraft Cleaner		12b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT
13a. STATE Florida	13b. COUNTY --	13c. CITY OR TOWN Miami	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nomia Sharpe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 265-43-6881		17. INFORMANT ADDRESS Mr. Donovan Falconer, (son) Miami, FL. 33147	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2089 IMMEDIATE CAUSE (a) Bronchopneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days-weeks
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage - right hemothorax and upper gastrointestinal					days
DUE TO, OR AS A CONSEQUENCE OF (c) Human T-Cell leukemia					6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 14, 1982 , to December 25, 1982 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 25, 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE Attending Physician		22c. DATE SIGNED 12/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY L. Schaefer		22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12- 30-82	23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		23d. LOCATION CITY OR TOWN STATE Miami Florida	
24. FUNERAL DIRECTOR MARSHALL'S FUNERAL HOME		25a. DATE RECEIVED BY REGISTRAR JAN 4 1983		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
4217 - 9th St NW: Washington, D.C.					

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 2 3 2 5 6 9					
CERTIFICATE OF DEATH					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Robert J. Familton					2a. DATE OF DEATH MONTH 12 DAY 25 YEAR 82					2b. HOUR 11:45 AM
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH April DAY 27 YEAR 1927		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 1 YEAR HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Zealand		7b. CITIZEN OF WHAT COUNTRY? New Zealand		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Deputy Treasurer		12b. KIND OF BUSINESS OR INDUSTRY Int'l Monetary Fund		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Allan MIDDLE G. LAST Familton					15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE LAST Cullen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-98-4231		17. INFORMANT ADDRESS Joan M. Familton, same as #13						
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 Cardiac Arrest IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Heart Failure, Stroke PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. 		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 		CITY OR TOWN 		COUNTY 		STATE
22a. I certify that (I) (this hospital) attended the deceased from Nov 25 19 82 to Dec 25 19 82 . that (I) (we) last saw the deceased alive on 12/25 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]					DEGREE MD			22c. DATE SIGNED 12/27/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.300 K. Kim					22e. ADDRESS 8921 Shady Grove Ct. Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 31, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			23d. LOCATION CITY OR TOWN Alexandria COUNTY Virginia STATE 			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Bethesda, Maryland 20814					PA 		25a. DATE REC'D. BY REGISTRAR Jan 5 1983			
					25b. REGISTRAR'S SIGNATURE [Signature]					

12-2-02

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 5 7 0							
1. FOR STATE REGISTRAR		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST <u>FAULCONER</u>		MIDDLE <u>M.</u>		LAST <u>FAULCONER</u>		2a. DATE OF DEATH		MONTH <u>12</u>		DAY <u>1</u>		YEAR <u>82</u>		2b. HOUR <u>3 30</u> <u>PM</u>	
3 SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH		MONTH <u>1</u>		DAY <u>6</u>		YEAR <u>1911</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>71</u> YRS		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.											
10 CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hosp.</u>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Meat Cutter</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Butchering</u>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>Md.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Takoma Pk.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>7502 Holly Avenue 20092</u>									
14. FATHER'S NAME FIRST MIDDLE LAST <u>William E. Faulconer</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Nellie Quann</u>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No</u>									
16b. SOCIAL SECURITY NO. <u>229-07-7677</u>				17. INFORMANT ADDRESS <u>7502 Holly Ave.</u> <u>Lorelle H. Faulconer Takoma Park, Md.</u>													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>1629</u> IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>ARTERIOSCLEROTIC HEART DISEASE</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) <u>was</u> <u>not</u> <u>at</u> <u>the</u> <u>hospital</u> attended the deceased from <u>1972</u> to <u>1 DECEMBER</u> 19 <u>82</u> , that (I) <u>was</u> <u>not</u> <u>at</u> <u>the</u> <u>hospital</u> saw the deceased alive on <u>30 NOVEMBER</u> 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <u>l</u> <u>did</u> <u>not</u> <u>view</u> the body after death.																	
22b. SIGNATURE <u>Morrill C. Quinam Jr.</u>				DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/1/82</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MORRILL C. QUINAM JR.</u>				22e. ADDRESS <u>11120 NEW HAMPSHIRE AVE., SILVER SPRING, MD</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/4/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Rockville, Maryland</u>									
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				P. O. Box 7428 ADDRESS <u>Sil. Spr., Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 8 - 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>							

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1913



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

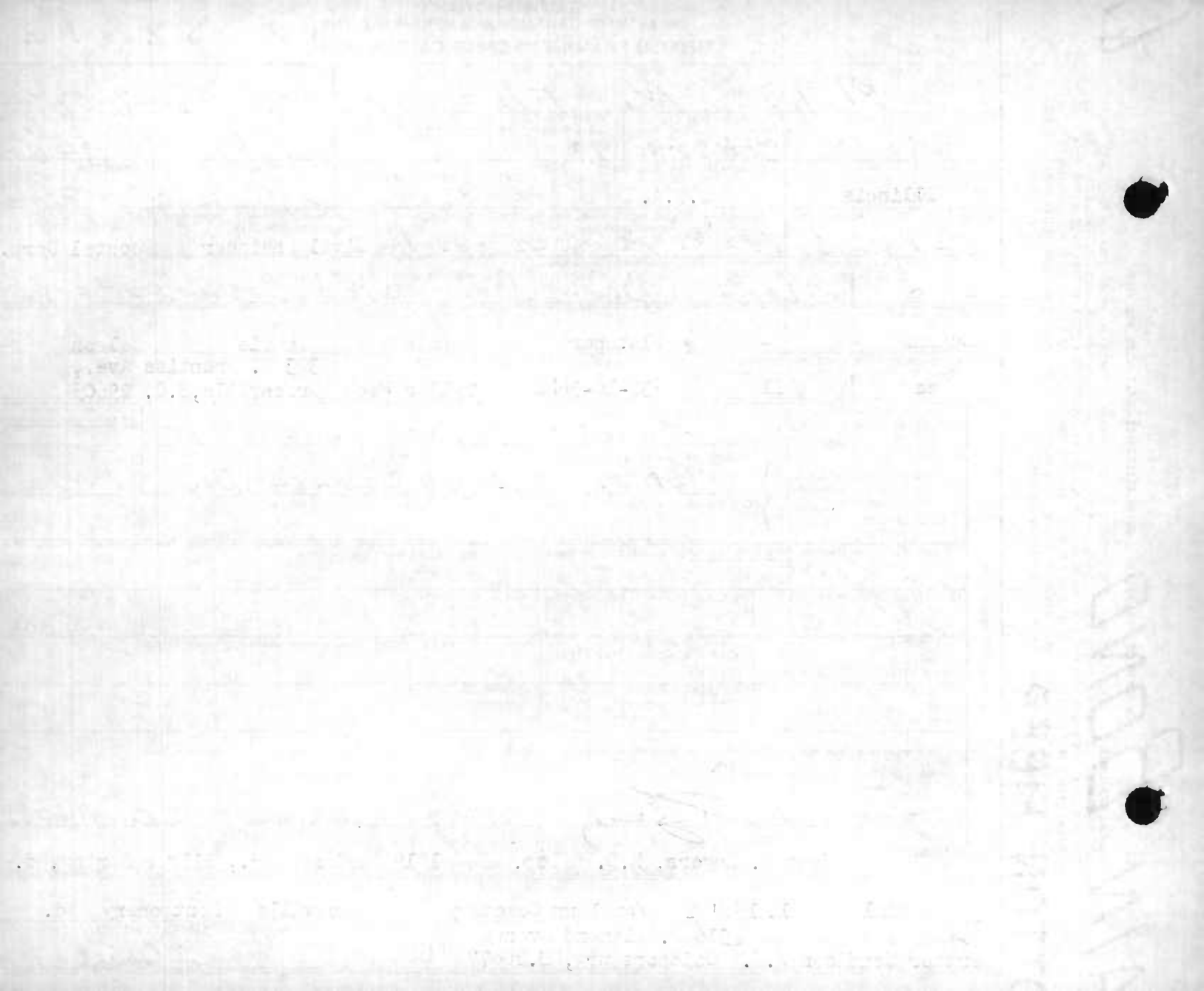
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-351-1521.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 3 2 5 7 1 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)		FIRST MAX	MIDDLE MILTON	LAST FEINSILBER	2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 3, 1982	2b. HOUR 10:00PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 20, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 316 ETHAN ALLEN AVENUE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) METEOROLOGIST		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				12b. INDUSTRY INDUSTRY OF COMMERCE		
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN TAKOMA PARK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 316 ETHAN ALLEN AVENUE		
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR FEINSILBER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA (UNASCERTAINABLE)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 1926-1928		17. INFORMANT ADDITIONAL ADDRESS ESTHER M. FEINSILBER, TAKOMA PARK, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE MYELOMA</u> 2030 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 20</u> , 19 <u>75</u> , to <u>DEC. 3</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Nov 18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Hubert J. Alpert</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HUBERT J. ALPERT, M. D.		22e. ADDRESS 8630 FENTON STREET, SILVER SPRING, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/5/1982		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH VIRGINIA
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25. DATE REC'D BY REGISTRAR DEC 8 1982		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR FOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 2 5 7 2	
1. DECEASED NAME (TYPE OR PRINT) Philip N. Fletcher			2a. DATE KNOWN OF DEATH Dec 9, 1982			2b. HOUR 8:45					
3. SEX M	4. RACE W	5. DATE OF BIRTH Oct 20, 1925	6. AGE (IN YEARS) 57	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Dec 11, 1982		2d. HOUR 12		2e. MIN 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Derwood		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH A CITY, GIVE STREET ADDRESS) 18803 Muncester Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer		12b. KIND OF BUSINESS OR INDUSTRY Bechtel Corp.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Derwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 18803 Muncester Rd			
14. FATHER'S NAME FIRST Eugene MIDDLE - LAST Fletcher				15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE Laurie LAST Nelson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 532-18-3448		17. INFORMANT Phyllis Webb ADDRESS 303 W. Prentiss Ave., Greenville, S.C. 29605					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Inf DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 4291 (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) Yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D. & Dep.				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. & Dep.				ADDRESS 1919 Seminary Rd., Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/82		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.			
24. FUNERAL DIRECTOR Grosakell Sanderson				316 E. Diamond Avenue, Gartner Sandison F.H. Gaithersburg, Md. 20877				25a. DATE REC'D. BY REGISTRAR DEC 16 1982			
				25b. REGISTRAR'S SIGNATURE John J. Canfield							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	3	2	5	7	3
1. FOR STATE REGISTRAR						REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) Mabel Frances Foose						2a. DATE OF DEATH MONTH 12 DAY 23 YEAR 82						2b. HOUR 11 ¹⁵ ^P _M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 11 DAY 07 YEAR 85		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD										
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Health Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --								
13a. STATE ---		13b. COUNTY ---		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3416 Texas Avenue SE								
14. FATHER'S NAME FIRST Joseph MIDDLE LAST Tomlinson				15. MOTHER'S MAIDEN NAME FIRST Estella MIDDLE LAST Waters												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Richard T. Foose				ADDRESS Same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Coronary Artery Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ---						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a																
19a. DATE OF OPERATION 9/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 												
22a. I certify that (I) (this hospital) attended the deceased from September 23, 1982 to September 23, 1982 , that (I) (we) last saw the deceased alive on September 23, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (below) (did not, allow the body after death).																
22b. SIGNATURE Benjamin A. Fennell, MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-24-82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin A. Fennell, MD		22e. ADDRESS 3220 Fennell Avenue, Md. 20855														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-28-82		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION CITY OR TOWN Wheeling COUNTY W. Va. STATE 										
24. FUNERAL DIRECTOR'S NAME Robert E. Wilhelm		ADDRESS Suitland, Md		25a. DATE REC'D. BY REGISTRAR JAN - 3 1983		25b. REGISTRAR'S SIGNATURE John J. Conner										

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 7 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph Fox			2a. DATE OF DEATH MONTH DAY YEAR 12-10-82			2b. HOUR 9:23p_M			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 12, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GROCCER		12b. KIND OF BUSINESS OR INDUSTRY FOODS	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2604 BEL PRE RD. #20906	
14. FATHER'S NAME FIRST MIDDLE LAST ISADORE FOX				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHAEL UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 219-10-6450		17. INFORMANT SILVER SPRING, MD. MR. IRWOOD FOX 2604 BEL PRE RD. (20906)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4249 Cardiac Arrest IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) Constrictive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) ENDORRHOIDS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-9 19 82 , to 10/11/82 , that (I) (we) last saw the deceased alive on 12-9 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Robert Kramer						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/11/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRAMER						22e. ADDRESS 8630 FENTON ST SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/12/82		23c. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR (NAME) SOLO LEVINSON & BROS., INC (21215)						25. DATE REC'D. BY REGISTRAR DEC 15 1982		26. REGISTRAR'S SIGNATURE John J. Conner	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10-10-51

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[Faint, illegible handwritten text and markings covering the lower half of the page, including what appears to be a signature and various scribbles.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 5 7 5	
1. STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RASHEED ANTHONY FRASER-STEWART			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 27 1982		2b. HOUR P.M. 7:38
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 25 1982		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. YRS. 2	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -		12b. KIND OF BUSINESS OR INDUSTRY -
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DELAWARE			13b. CITY OR TOWN DOVER	13c. STREET ADDRESS 3009C MYRTLE STREET	
14. FATHER'S NAME FIRST MIDDLE LAST MERVIN ALLAN STEWART-FREDERICK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAWN CYNTHIA FRASER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS DAWN FRASER-STEWART, 3009C MYRTLE STREET,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7469 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGENITAL HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) -			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DOVER DELAWARE 19901		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 27 19 82 , to DECEMBER 27 19 82 , that (I) (we) last saw the deceased alive on DECEMBER 27 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>LoPreiato ms</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 27 Dec 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOPREIATO		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/82		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Queens New York					
24. FUNERAL DIRECTOR NAME ADDRESS Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852				25a. DATE REC'D. BY REGISTRAR JAN 5 1983 REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) SAMUEL FRIEDMAN					2a. DATE OF DEATH MONTH DAY YEAR 12 - 1 - 82					2b. HOUR 11:15 P^M
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 - 1 - 93		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shoe Store owner		12b. KIND OF BUSINESS OR INDUSTRY Retn. L		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE VIRGINIA		13b. COUNTY ARLINGTON		13c. CITY OR TOWN ARLINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3156 NORTH 18th STREET		
14. FATHER'S NAME FIRST MIDDLE LAST JOEL FRIEDMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER (UNASCERTAINABLE)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 578-01-6699		17. INFORMANT ADDRESS DR. SHOLOM H. FRIEDMAN, FALLS CHURCH, VA.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1570 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Obstructive jaundice DUE TO, OR AS A CONSEQUENCE OF (c) Possible Co. of the head of the pancreas.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. Shakir					DEGREE MD			22c. DATE SIGNED 12.1.82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMLETH T.A. SHAKIR					22e. ADDRESS Hebrew Home 6121 Montrose Rd Rockville MD					
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 12/3/1982		23c. NAME OF CEMETERY OR PLACE OF BURIAL BETH PEILOH CONGREGATION CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR DEC 14 1982		25b. REGISTRAR'S SIGNATURE [Signature]		
23e. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.										

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #16a Film G575 1/4/83 rc

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Freilicher			2a. DATE OF DEATH MONTH DAY YEAR December 10, 1982			7b. HOUR 1:30 A.M.								
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 71		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS HOURS MIN						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn, N.Y.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8813 Sundale Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Owner			12b. KIND OF BUSINESS OR INDUSTRY Sproting Gds.					
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST BARUCH FREILICHER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNY RAPPAPORT			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. W. W. II. 219-05-1979					
17. INFORMANT ADDRESS Silver Spring, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADVANCED PARKINSON'S disease 3320 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from Aug 1974 to Dec 10 1982 ; that (I) (we) lost saw the deceased alive on Dec 9 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22b. SIGNATURE Donald A. O'Kieffe DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/10/82		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/12/82			23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn.			23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church; Fairfax; Va.					
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG			ADDRESS MEMORIAL CHAPELS			DATE DEC 14 1982			SIGNATURE John J. Danzansky					
1170 Rockville Pike; Rockville, Md. 20852														

MEDICAL CERTIFICATION

THEATRE OF THE WORLD
RECEIVED FROM THE THEATRE OF THE WORLD

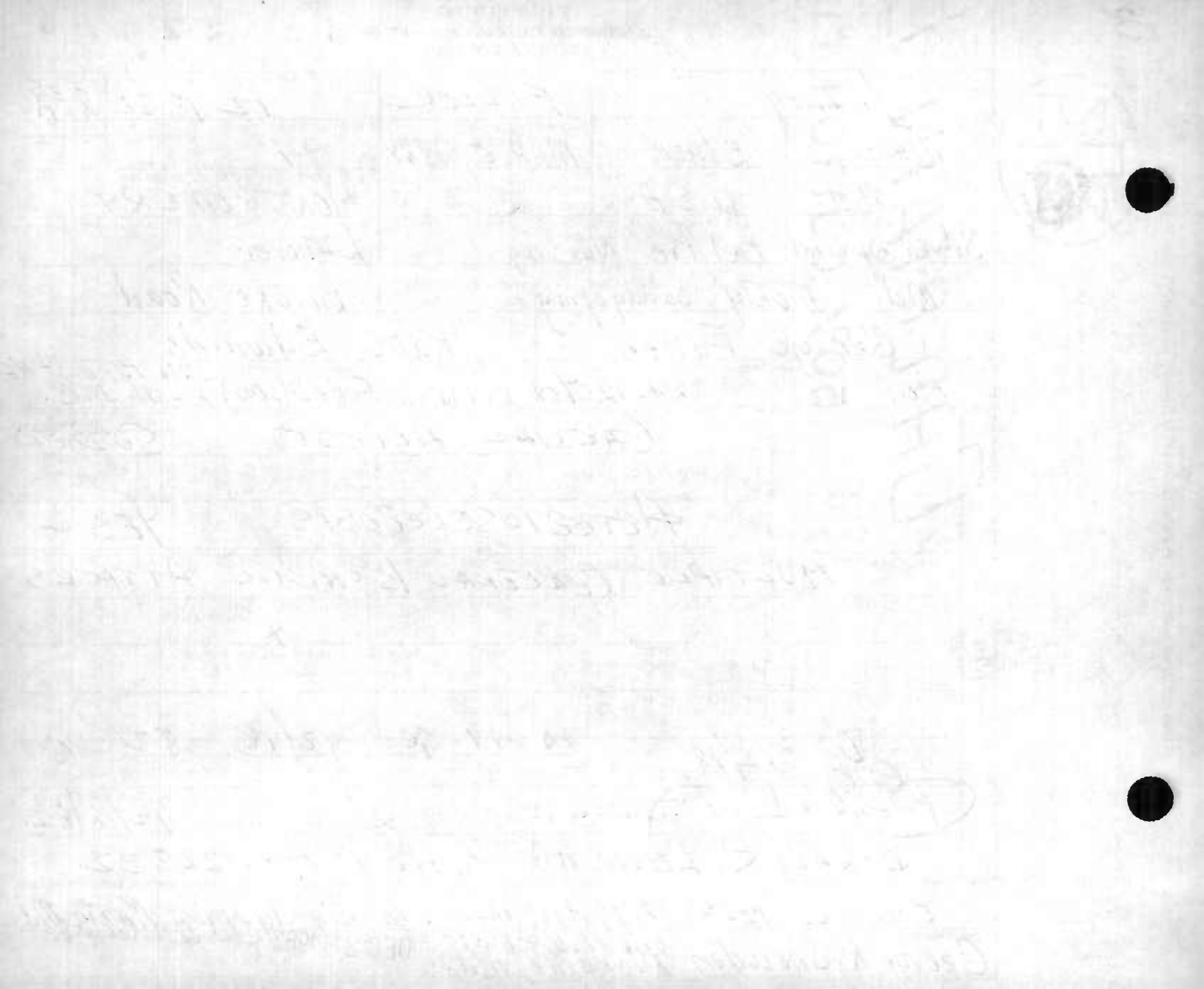
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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
8 2 3 2 5 7 8										
FOR 1. STATE REGISTRAR										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) <u>IRVING</u>					2a. DATE OF DEATH MONTH <u>12</u> DAY <u>18</u> YEAR <u>82</u>					2b. HOUR <u>8³⁵</u> A.M.
3. SEX <u>Male</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH DAY <u>MAR. 5</u> MONTH <u>1888</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>94</u> YRS.		7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		7. IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.				
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Bel Pre Nursing</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Laborer</u>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u>		13b. COUNTY <u>Montg</u>		13c. CITY OR TOWN <u>Sandy Spring</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>Brooke Road</u>		
14. FATHER'S NAME FIRST <u>George</u> MIDDLE <u>Fuller</u> LAST <u></u>					15. MOTHER'S MAIDEN NAME FIRST <u>Katie</u> MIDDLE <u>Edwards</u> LAST <u></u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>					16b. SOCIAL SECURITY NO. <u>214-12-7608</u>		17. INFORMANT ADDRESS <u>1271 Penn. St NE</u> <u>Benjamin Fuller (son) Wash. D.C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for 10-15 lines) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost (b) <u>ARTERIO SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>YES -</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>MULTIPLE CEREBRAL ISCHEMIC ATTACKS</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>12</u> <u>18</u> <u>82</u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <u>1271 Penn St NE</u> CITY OR TOWN <u>Washington</u> COUNTY <u>D.C.</u> STATE <u>D.C.</u>					
22a. I certify that (1) this hospital attended the deceased from <u>12/18/82</u> to <u>12/18/82</u> , that (1) we last saw the deceased alive on <u>12/18/82</u> , and that (2) our opinion death occurred on the date and hour and from the causes stated above.										
22b. SIGNATURE <u>Donald R. Lewis MD</u>					DEGREE <u>MD</u>		22c. DATE SIGNED <u>12/18/82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DONALD R. LEWIS MD</u>					22e. ADDRESS <u>OLNEY, Md 20832</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>12-22-82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mutual Mem. Cem.</u>		23d. LOCATION CITY OR TOWN <u>Sandy Spring</u> COUNTY <u>Montg</u> STATE <u>Md.</u>			
24. FUNERAL DIRECTOR NAME <u>George R. Snowden</u>					24b. ADDRESS <u>246 N. Wash. St</u> <u>Rockville, Md.</u>		25a. DATE RECEIVED BY MORTUARY <u>DEC 23 1982</u>			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 5 7 9			
1. FOR STATE REGISTRAR					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Frederick FRANK Galenski, Sr.					2a. DATE OF DEATH MONTH DAY YEAR 12-8-82				2b. HOUR 20 MIN 11 A M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Oct. 28, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. OCCUPATION Retired Building Contractor		12b. KIND OF BUSINESS OR INDUSTRY Self Employed					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 20737		13b. CITY OR TOWN Prince Georges		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Riverdale		13d. STREET ADDRESS 4802 Longfellow Street							
14. FATHER'S NAME FIRST MIDDLE LAST Walter Galenski					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Zaleaski								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF KNOWN, GIVE YEAR OR DATES) WW 11		17. INFORMANT ADDRESS Bertha Galenski Same as #13 (Wife)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the pancreas DUE TO, OR AS A CONSEQUENCE OF (c) Lung metastasis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from 11 , 19 82 , to 12/8 , 19 82 , that (1) (we) lost saw the deceased alive on 12/7 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Jay Weiner MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/9/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner MD					22e. ADDRESS 4701 Randolph Rd Rockville, Md								
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 12/11/82		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE S. Dearfield Franklin Mass.					
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland					25a. DATE REC'D. BY REGISTRAR DEC 13 1982							25b. REGISTRAR'S SIGNATURE John J. Conner	

Yes	IV II	048 10 2714	Bertie Colomaki	Case no 413 (1116)	Salisbury
Salter			Calomaki		
46. 30737	George	Riverdale	x	1802 Longfellow Street	
Silver Spring		Holy Cross Hospital		Retired Building Contractor - employed	
Transcendental	U.S.A.				
WHITE		Dr .			

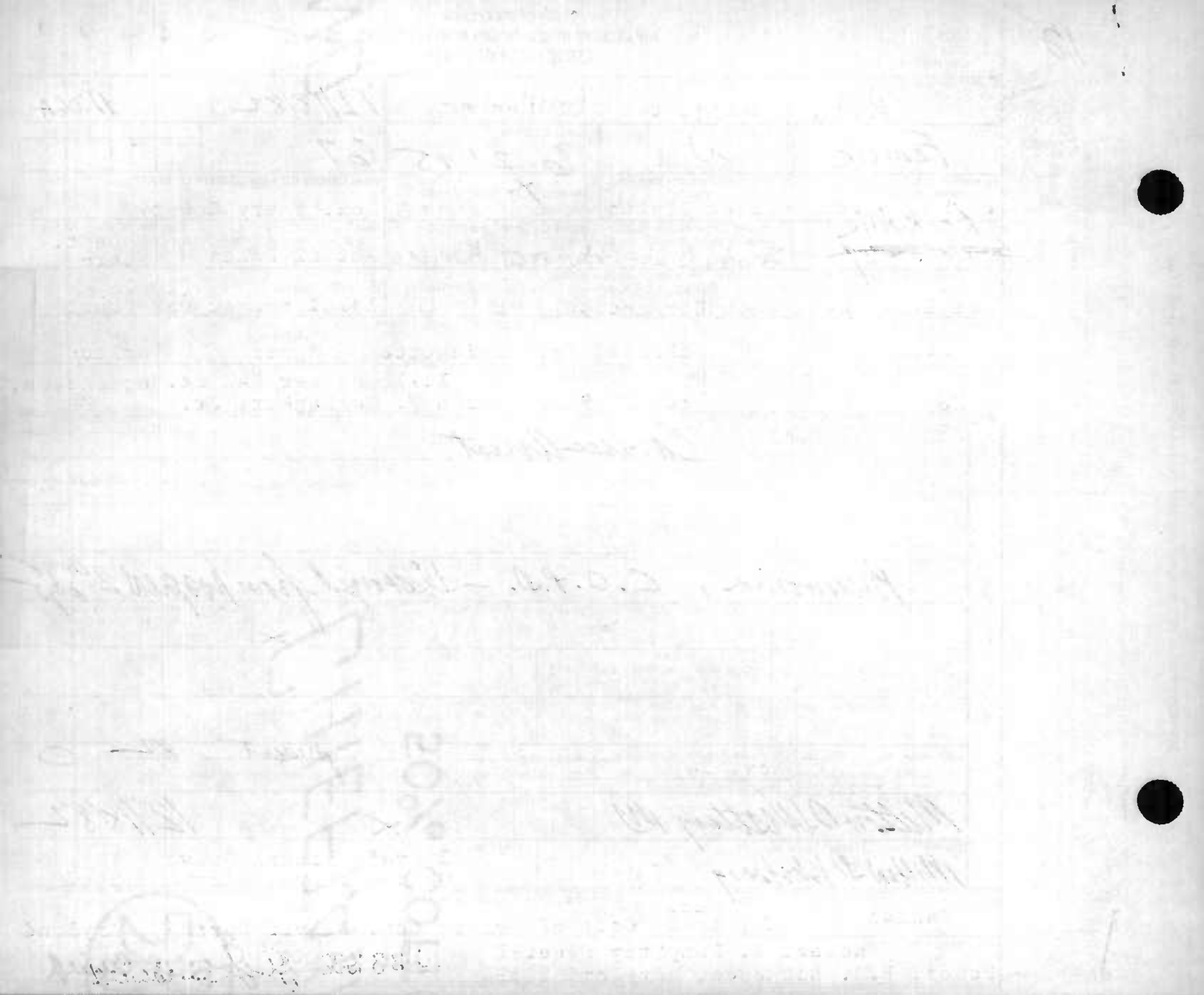
Francis
 Francis Macchia's home
 12/11/82 St. Stanislaus Con.
 P. Montfield Franklin Mass.
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 5 8 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Rita Margaret Gallagher				2a. DATE OF DEATH MONTH DAY YEAR 12/18/82		2b. HOUR 11:06A^M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6 21 15		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. PLACE OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail Sales	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Montgomery 13d. CITY OR TOWN Germantown				13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS (20874) 18761 Summer Oak Court	
14. FATHER'S NAME FIRST John MIDDLE McBride, Sr. LAST Bridgette				15. MOTHER'S MAIDEN NAME FIRST Agnes MIDDLE Dalton LAST Dalton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-36-9455		17. INFORMANT ADDRESS 18779 Summer Oak Ct. Germantown, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia, C.O.P.D. - Discharged from hospital 2 days ago							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Jan 13, 1981 to present 19 82 , that (I) (we) first saw the deceased alive on Nov. 24, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.							
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Milton D. Westberg				22b. ADDRESS 2 Professional Drive Gaithersburg, Maryland 20879			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 22, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25a. DATE REC'D. BY REGISTRAR DEC 23 1982 25b. REGISTRAR'S SIGNATURE John J. Canfield			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 5 8 1			
1- FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES CAREY CAUGHLIN GARRISON						2a. DATE OF DEATH MONTH DAY YEAR 12 6 82				2b. HOUR 10:04 PM			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11 16 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? American		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOSP. 1500 FOREST GLEN RD. S.S. HOLY CROSS				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistician		12b. KIND OF BUSINESS OR INDUSTRY State Dept.					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN 20795 Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10225 Kensington Parkway					
14. FATHER'S NAME FIRST MIDDLE LAST Daniel J. Caughlin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret May Smith				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. -----				17. INFORMANT ADDRESS 242 Chenault Rd 40502 Mrs. John B. Roberts Lexington Ky.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intracerebral hemorrhage</u> 4310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> 19 <u>82</u> to <u>12/6</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>12/6</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Richard H. Pallen				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/7/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD H. PALLAN				22e. ADDRESS 10400 CONNECTICUT AVE, KENSINGTON MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-8-82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria VA.		25a. DATE REC'D. BY REGISTRAR DEC 13 1982					
24. FUNERAL DIRECTOR Warner E. Pumphrey Inc.		8434 Ga. Ave. Sil. Spr. Md.		25b. REGISTRAR'S SIGNATURE Sam J. Carver									

MEDICAL CERTIFICATION

29

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		Helen V. Geary		12/3/82		4:30 P			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		1-6-93		89 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
NEW YORK		USA				MONTGOMERY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
WHEATON		UNIVERSITY NURSING HOME		SEAMSTRESS					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		14. STREET ADDRESS			
Washington, D.C.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		215 Emerson St. N.W.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
JOHN		MARY		no		06 10 7085		Mrs. F.J. Duane 343 S. Sarasota, Fla.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
PART I. DEATH WAS CAUSED BY:						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
IMMEDIATE CAUSE (a) CVA									
4292								8 YEARS	
DUE TO, OR AS A CONSEQUENCE OF									
(b) ASCVD									
DUE TO, OR AS A CONSEQUENCE OF									
(c) CBS								8 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY		21e. LOCATION	
		HOUR A.M. MONTH DAY YEAR				CITY OR TOWN		COUNTY STATE	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. SIGNATURE		22c. DATE SIGNED	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		DEGREE		12/3/82	
22a. I certify that (I) (this hospital) attended the deceased from 1/24/75, 19__, to 12/3/82, 19__, that (I) (we) lost saw the deceased alive on 12/1/82, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS		22d. SIGNATURE		22e. DATE SIGNED		22f. REGISTRAR'S SIGNATURE	
WALTER GOORN, M.D.		2309 Shorefield Rd		WHEATON, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. REGISTRAR'S SIGNATURE	
Burial		Dec. 6, 1982		Gate of Heaven		Silver Spring, Md.			
24. FUNERAL DIRECTOR		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE	
W.W. Taltavull		DEC 9 1982		John J. Conner					
4748 Wisc. Ave. N.W.		Wash. D.C. 20016							

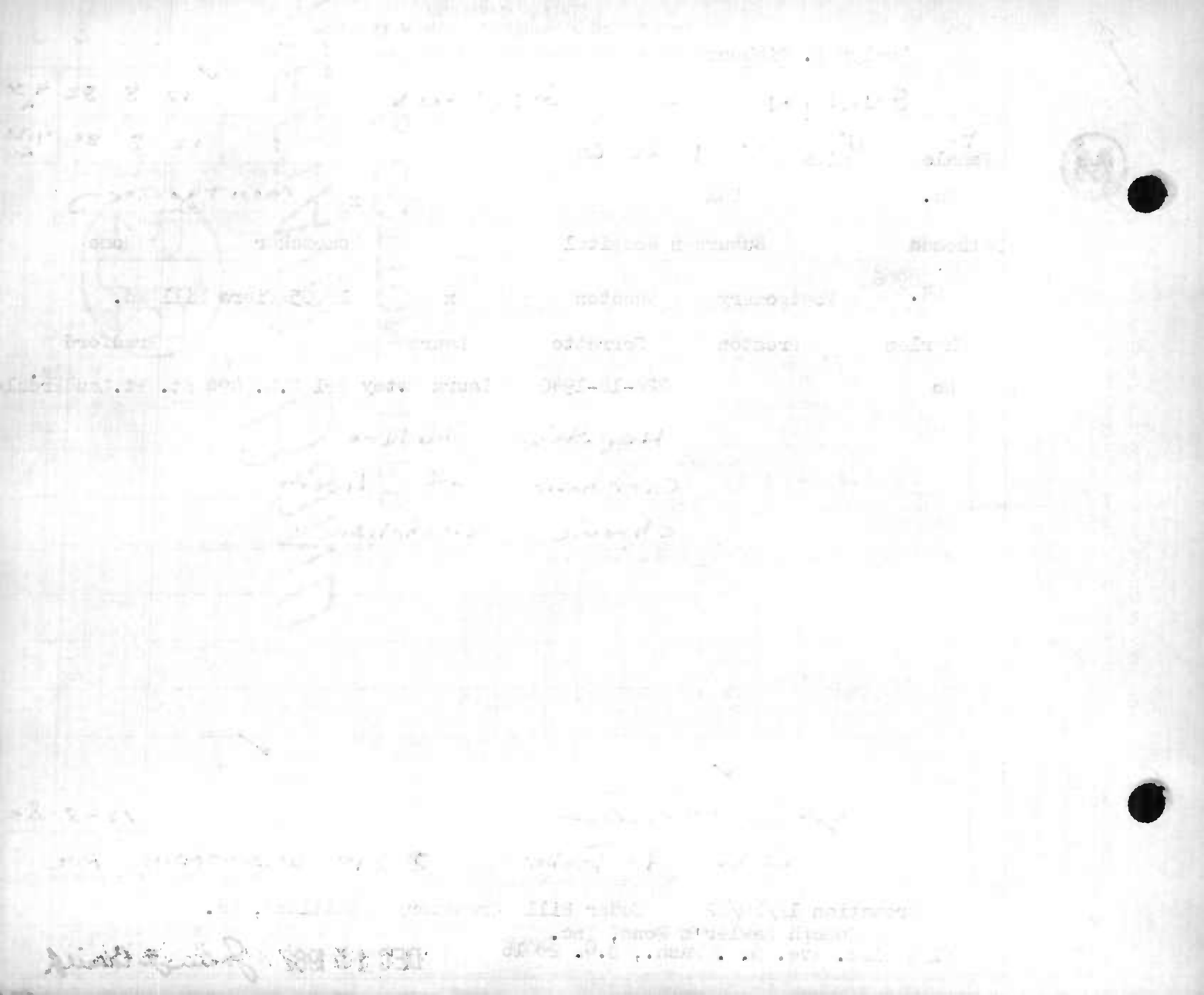
144

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR Evelyn S. Gibbons MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 8 2 3 2 5 8 3									
1. DECEASED NAME (TYPE OR PRINT) Evelyn S. Gibbons						20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 12 DAY 8 YEAR 82		21. HOUR 4:30 A.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 5 DAY 9 YEAR 22	6. AGE (IN YEARS) LAST BIRTHDAY 60 YRS.	7. IF UNDER 1 YR. MONTHS 0 DAYS 0	8. IF UNDER 24 HRS. HOURS 0 MIN. 0	22. DATE PRONOUNCED DEAD MONTH 12 DAY 8 YEAR 82		23. HOUR 4:30 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE 20906 Md.		13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 12005 Viers Mill Rd.			
14. FATHER'S NAME FIRST Charles MIDDLE Preston LAST Serrette				15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE Bradford LAST Bradford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 228-18-1940		17. INFORMANT ADDRESS Laura Estey 221 N.W. 49th St. Ft. Lauderdale, Fla.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 5712 IMMEDIATE CAUSE (a) Hepatic Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF (c) chronic alcoholism									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE John F. Tauber		TITLE (SPECIFY) M.D.				MEDICAL EXAMINER		DATE SIGNED 12-8-82	
EXAMINER'S NAME (TYPE OR PRINT) John F. Tauber		ADDRESS 8 218 Wisc. Ave							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/10/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN Suitland, Md. COUNTY STATE			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 Wisc. Ave. N.W. Wash., D.C. 20016 ADDRESS				25a. DATE REC'D. BY REGISTRAR DEC 15 1982		25b. REGISTRAR'S SIGNATURE John J. Connel			



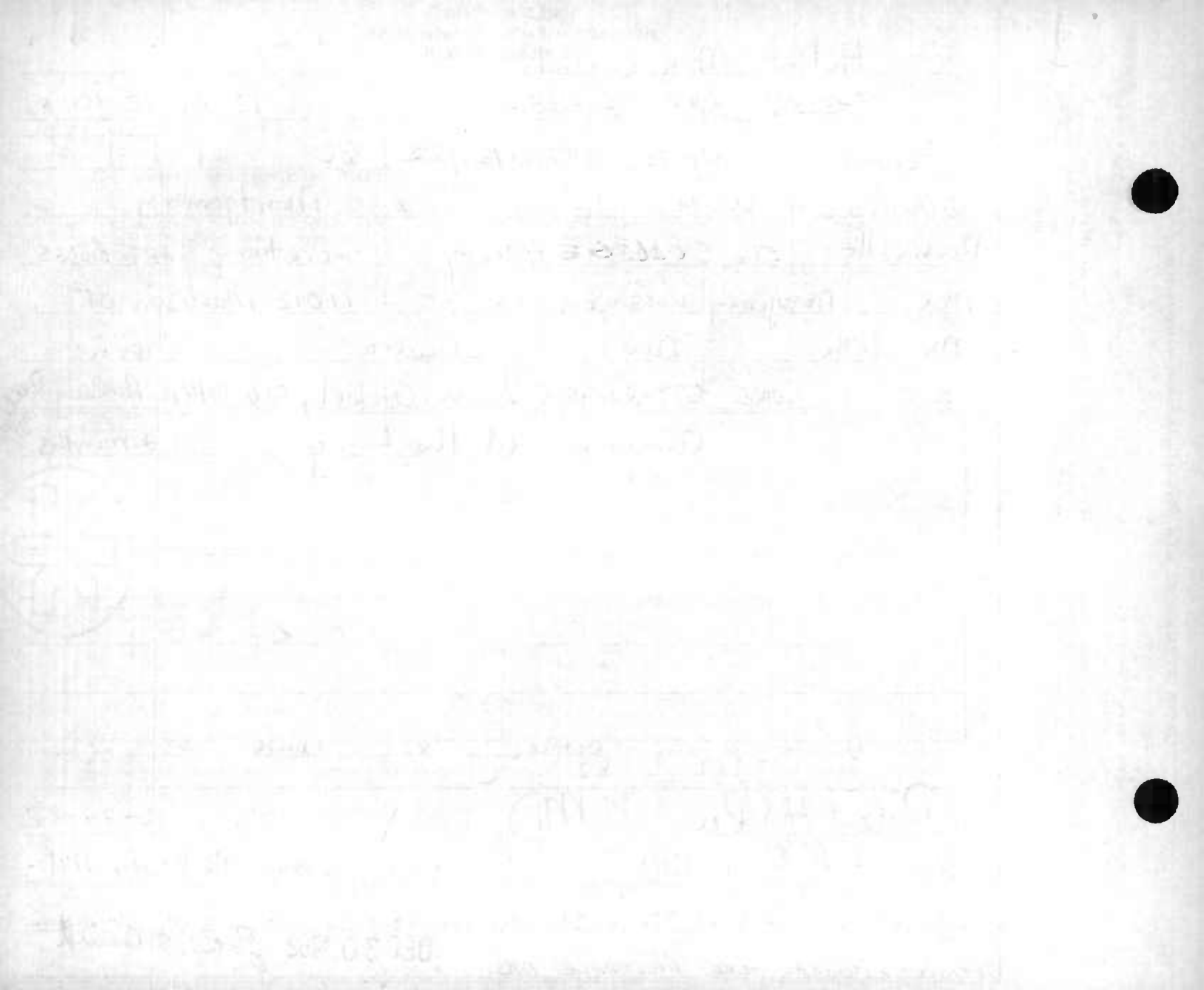
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 3 2 5 8 4			
1. FOR STATE REGISTRAR <i>Helen May Giebel</i>							
1. DECEASED NAME (TYPE OR PRINT) <i>HELEN MAY GIEBEL</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>12 24 82</i>		2b. HOUR <i>10 A.M.</i>	
3. SEX <i>FEMALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>SEPTEMBER 18, 1922</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>60</i>	IF UNDER 1 YEAR MONTHS DAYS <i>YRS.</i>		IF UNDER 24 HRS. HOURS MIN. <i>YRS.</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Rockville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>516 COLLEGE PARKWAY</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>APT. BLDGS.</i>	
13a. STATE <i>md</i>				13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Merileth Davis</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Claudia Green</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS <i>Vicki Giebel, 516 College Parkway Rockville, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Lung</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>October</i> 19 <i>82</i> , to <i>Death</i> 19 _____, that (I) (we) last saw the deceased alive on <i>12/17</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert H Blee MD</i>				22c. DATE SIGNED <i>12-24-82</i>		22d. ADDRESS <i>8218 Wisconsin Ave, Bethesda Md</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>				23b. DATE <i>DEC. 27, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CREMATORY</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>SUITLAND P.G.CO. MARYLAND</i>				23e. DATE OF BURIAL <i>DEC 30 1982</i>			
24. FUNERAL DIRECTOR NAME <i>CHAMBERS FUNERAL HOME</i>				24b. ADDRESS <i>RIVERDALE MD.</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with at 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 8 5 REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR P M			
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ralph (NMN) Gilley				December 9, 1982				3:40 P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 13, 1929		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 53		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Windowcleaner		12b. KIND OF BUSINESS OR INDUSTRY Commercial			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13b. STREET ADDRESS Route 4, Box 399			
13a. STATE Delaware		13b. COUNTY Kent		13c. CITY OR TOWN Milford							
14. FATHER'S NAME FIRST MIDDLE LAST Walter Gilley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Dollar							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT ADDRESS R. Delphia Gilley, wife, same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Small cell carcinoma of lung relapse DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours one month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Central nervous system involvement with small cell carcinoma											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 16 November 1982, to 9 December 1982, that (if (we) last saw the deceased alive on 9 December 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated.											
22b. SIGNATURE Dwight Kaufman MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED Dec. 10, 1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dwight Kaufman MD				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 13, 1982		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows		23d. LOCATION CITY OR TOWN COUNTY STATE Milford Kent Delaware					
24. FUNERAL DIRECTOR William A. Berry, Jr., Milford, DE				25a. DATE REC'D. BY REGISTRAR DEC 22 1982				25b. REGISTRAR'S SIGNATURE John J. Cawley			

BP

3

Items #500 per phone call w/Fuh.

STATE OF MARYLAND

FOR
1- STATE Home 12/21/82 rc
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 2 3 2 5 8 6

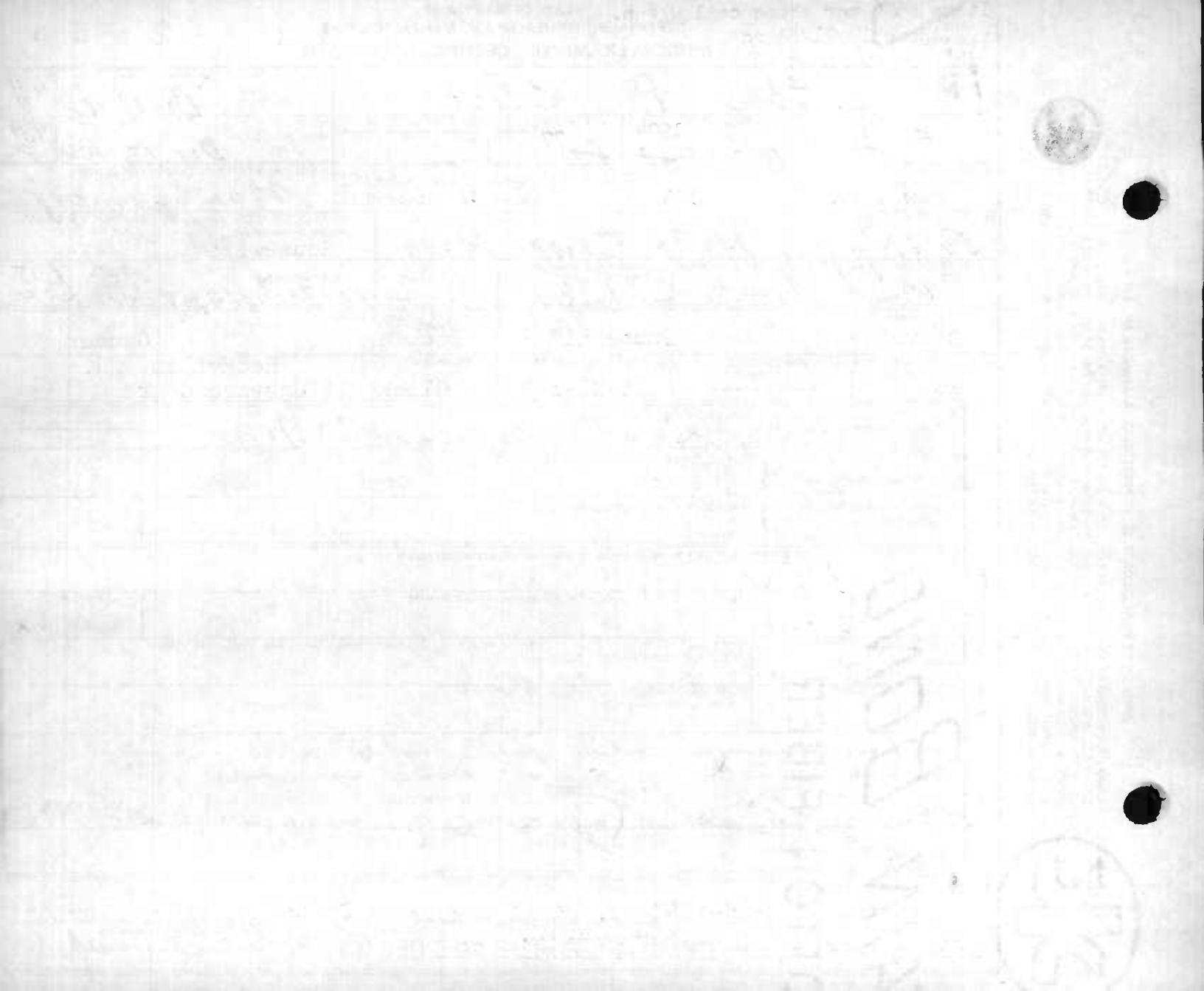
1. DECEASED NAME (TYPE OR PRINT) Lottie P. Glick		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Dec 17 1982	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Dec 25 1904	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 77
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA	
10. CITY OR TOWN OF DEATH Si'l Spg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp	
13a. STATE MD		13b. COUNTY Montgomery	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Taubenkimmel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beckie Gruber	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 261-38-1406	
17. INFORMANT Rockville, Md.		17. INFORMANT Al Glick; 11 Harvard Court	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial D.S. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 4291			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None			
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE [Signature]		TITLE (SPECIFY) MD	
EXAMINER'S NAME (TYPE OR PRINT)		MEDICAL EXAMINER	
ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-20-1982	
23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Opalacka, Dade, Florida	
24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg Chapels; 1170 Rockville Pike		25a. DATE REC'D. BY REGISTRAR DEC 21 1982	
		REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

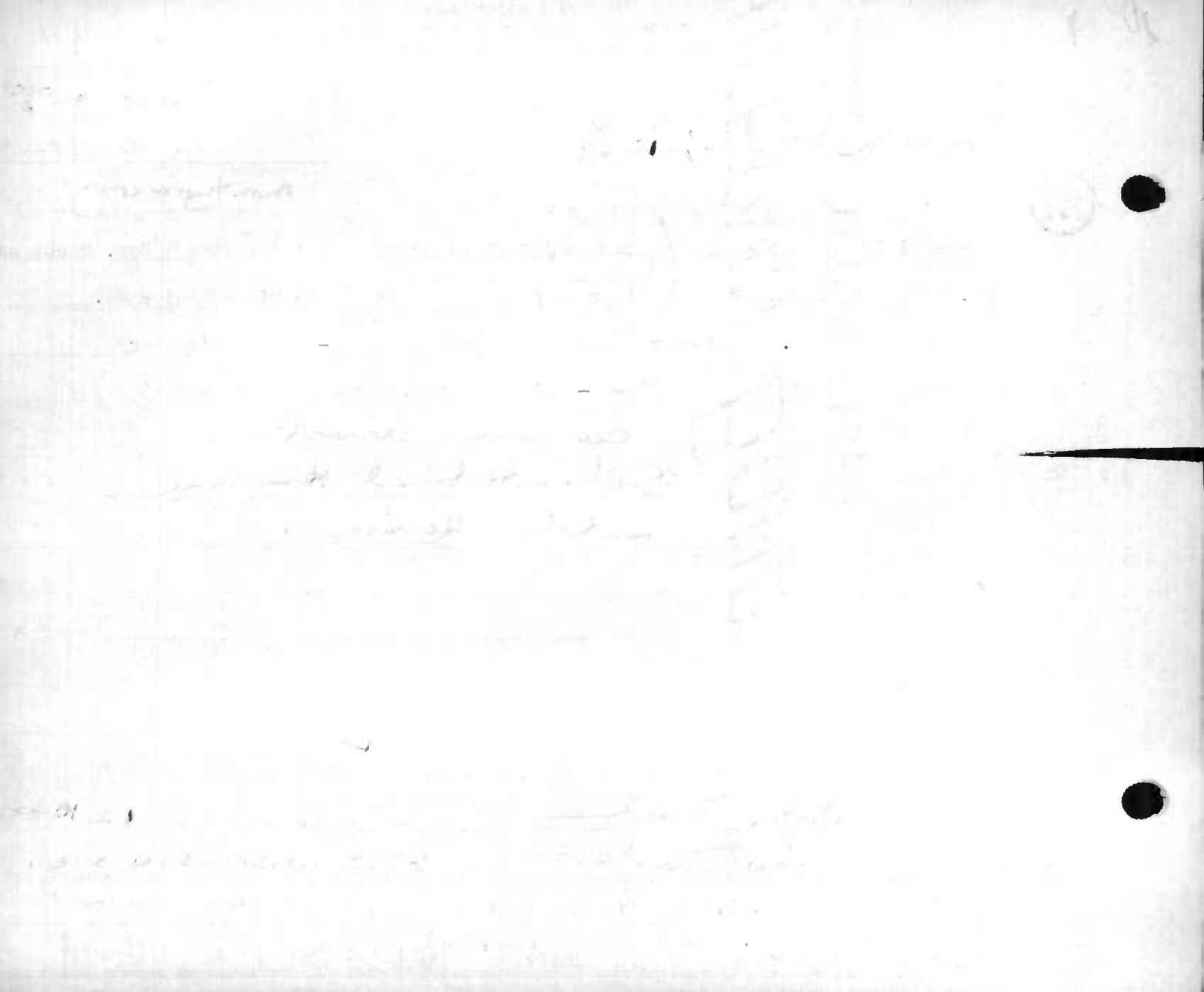
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82



FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		3 2 5 8 1	
1- STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		H. MARKS GLOVER		2a. DATE KNOWN OF DEATH ESTI- MATED	
3. SEX male		4. RACE white		2b. DATE PRONOUNCED DEAD	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		2d. DATE PRONOUNCED DEAD	
9a. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC arrest</u> 5533 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <u>Gastrointestinal Hemorrhage</u> (c) <u>Abdominal Hernia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)	
ACTUAL SIGNATURE		M.D.		DATE SIGNED	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR NAME		24a. CITY OR TOWN		24b. STATE	



1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HYMAN			2. DATE OF DEATH MONTH DAY YEAR December 3 1982			2b. HOUR 0245 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR July 4, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Glazier		12b. KIND OF BUSINESS OR INDUSTRY Glass Company	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth (Unknown)		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II			
17. INFORMANT NAME ADDRESS Anna Goldberg; 11550 Stewart Lane; Silver Sp., Maryland 20904		18. SOCIAL SECURITY NO. 217-01-2343					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Distal Pullets DUE TO, OR AS A CONSEQUENCE OF (c) Distal Pullets		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/1/82 to 12/3/82 , that (I) (we) lost saw the deceased alive on 12/1/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mark Eig		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MARK EIG		22e. ADDRESS 9801 GEORGIA AVE. SSPG MD. 20902					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 5, 82		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25. DATE REC'D. BY REGISTRAR DEC 6 1982			
26. REGISTRAR'S SIGNATURE John J. Canine				27. ADDRESS 1170 Rockville Pike; Rockville, Maryland 20852			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF NEW YORK
IN SENATE
JANUARY 18, 1907.

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
FOR THE YEAR 1906.

ALBANY:

1907.

THE LAND OFFICE OF THE STATE OF NEW YORK
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF
THE REPORT OF THE COMMISSIONER OF THE LAND OFFICE
FOR THE YEAR 1906, AND TO TRANSMIT THE SAME
TO THE SENATE, AS PROVIDED BY CHAPTER 108
OF THE LAWS OF 1906, AND BY CHAPTER 108
OF THE LAWS OF 1907.

OFFICE OF THE
COMMISSIONER OF THE
LAND OFFICE
STATE OF NEW YORK
ALBANY

1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 8 9

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
HARRY GOLDSTEIN		12-15-82		10:28 A.M.	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	White	8-8-1893	89 YRS.	IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
New York	U. S. A.		Montgomery MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY		
Rockville	HEBREW HOME of Washington	Salesman	Silverware		
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS	
MD	MONTGOMERY	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6105 Montrose Road	
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME	16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Max Goldstein	Sarah (Unknown)	No			
16b SOCIAL SECURITY NO.	17 INFORMANT	18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1519 Cardiorespiratory Arrest			
211-24-3290	Lester P. Cohen	DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Ca of the Stomach			
17a RES. Lockwood Drive, #1-2 Silver Spring, Maryland		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	P.M. 19				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED		
R. Shakir	MD		12/15/82		
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS				
RAMLETH T.A. SHAKIR	Hebrew Home, Montrose Rd Rockville MD 20852				
23a BURIAL, CREMATION, REMOVAL	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE		
Burial	12/19/1982	Lakeside Memorial Park	Miami Dade, Florida		
24 FUNERAL DIRECTOR		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Donald M. Stein Hebrew Memorial F.H. 232 Carroll Street, N. W. Washington, D. C.		DEC 21 1982		John J. Givens	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 2 3 2 5 9 0 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY GOLDVARG					2a. DATE OF DEATH MONTH DAY YEAR 12 7 82			7b. HOUR 12 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 20 15		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. STATE Pennsylvania					13b. CITY OR TOWN Pittsburgh		13c. STREET ADDRESS 5837 Darlington Rd. (15217)		
14. FATHER'S NAME FIRST MIDDLE LAST Abram Goldvarg					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Silverberg				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 173-12-2035		17. INFORMANT ADDRESS Edward H. Goldvarg; 3951 Blvd., Dr., Pitt., Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1830 IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of Ovary DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos 9 mos									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 11/29 , 19 82 , to 12/7 , 19 82 , that (I) (we) last saw the deceased alive on 12/6 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G. Leonard Gold DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/7/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Leonard Gold, MD					22e. ADDRESS 8630 Fenton Street; Silver Spring, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/82		23c. NAME OF CEMETERY OR CREMATORY ADATH JESHURUN		23d. LOCATION CITY OR TOWN COUNTY STATE Wildwood; Alleghaney; Pa.			
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG CHAPELS 1170 Rockville Pike; Rockville, Maryland 20852					25a. DATE REC'D. BY REGISTRAR DEC 9 1982				

BP

THE UNIVERSITY OF CHICAGO
LIBRARY
CHICAGO, ILL.



CHICAGO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 9 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <i>Dorothy Goldwyn</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>12-14-82</i>				2b. HOUR <i>1:07</i> M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 02 97</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Silver Spring Md</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE <i>D.C.</i>		13b. CITY OR TOWN <i>Washington</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3001 Veazey Terrace, N.W., #1206</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Davis</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rose Labov</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>165-05-0789</i>		17. INFORMANT ADDRESS <i>Rip Davis; 5729 27th Street, N.W.; Wash., D.C.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>0389</i> IMMEDIATE CAUSE (a) <i>Cardiovascular Collapse</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>SEPSIS RENAL FAILURE</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>12/10</i> , 19 <i>82</i> , to <i>12/14</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>12/11</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Penny Bisk</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/14/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PENNY BISK MD</i>				22e. ADDRESS <i>8630 PENIBON ST SILVER SPRING MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPRINT) <i>Burial</i>		23b. DATE <i>12/16/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King David Memorial Gdn.; Fairfax Church; Fairfax, Va.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i>				25a. DATE REC'D. BY REG. CLERK <i>DEC 17 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>			
1170 Rockville Pike; Rockville, Md. 20852									

BP

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Medical Examiner
cleared

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

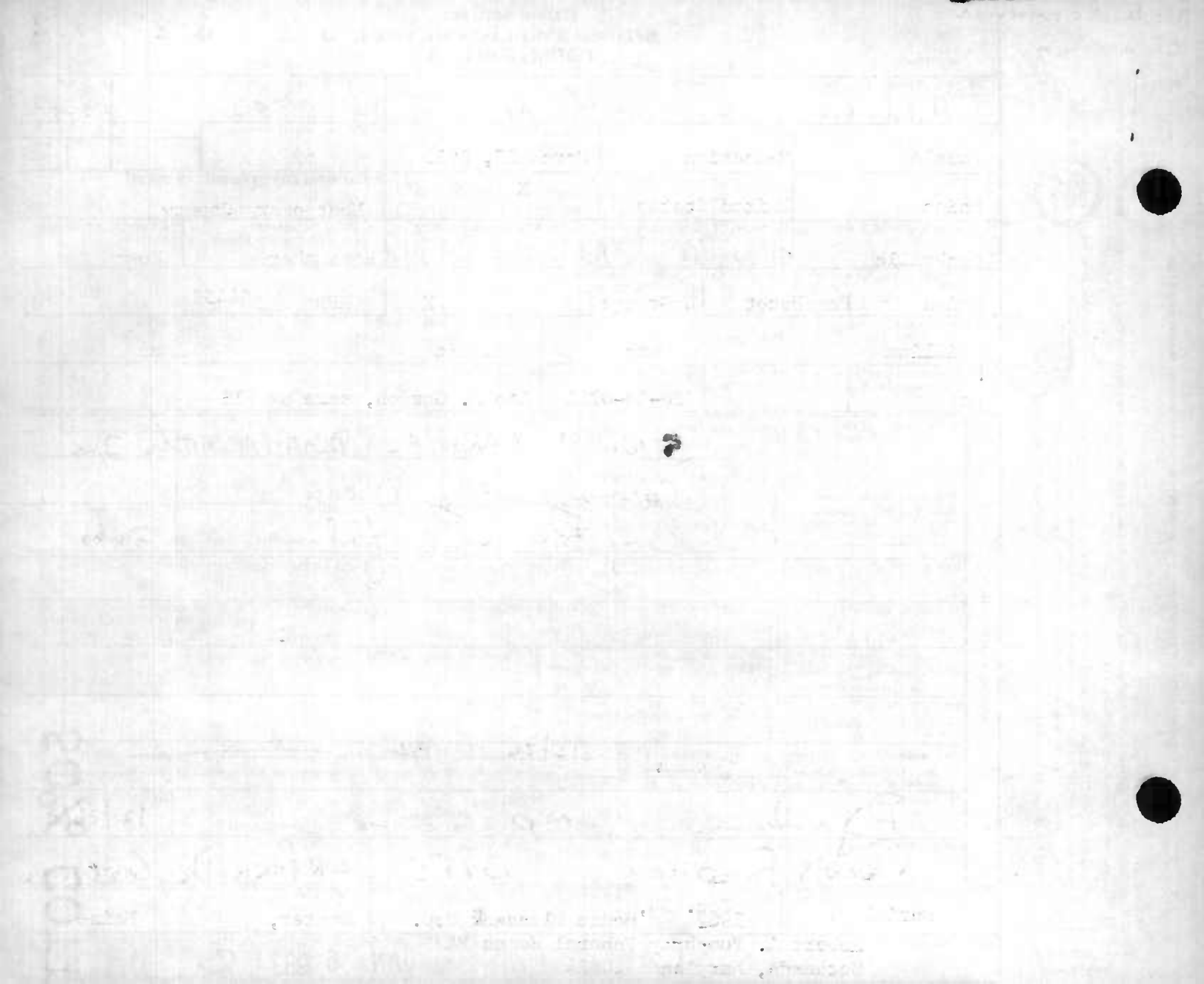
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 9 2

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: Madeline E. Last: Gordon			2a. DATE OF DEATH MONTH DAY YEAR 12-26-82		2b. HOUR 2045 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 29, 1913		
6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		9b. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		10. CITY OR TOWN OF DEATH Rockville		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maine		13b. COUNTY Penobscot		13c. CITY OR TOWN LaGrange		
14. FATHER'S NAME FIRST MIDDLE LAST William Dorr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Ames		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
17. SOCIAL SECURITY NO. 020-24-0711		18. INFORMANT ADDRESS Leo E. Gordon, same as #13				
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 Sudden Cardiac Death (Arrhythmia) 2 hrs DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure 2 hrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/26, 1982, to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Dennis Frigoman		DEGREE MO		22c. DATE SIGNED 12/26/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis Frigoman		22e. ADDRESS 1315E DEER PARK DR, GAITHERSBURG				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Mount Pleasant Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Dexter, Maine		24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes PA Bethesda, Maryland 20814				
25a. DATE REC'D. BY REGISTRAR JAN 6 1983		25b. REGISTRAR'S SIGNATURE John J. Carver				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 9 3

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. MONTH DAY YEAR		2b. HOUR	
MARIA CHOVANEC GRANT		DECEMBER 18 1982		1246am	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))	7. IF UNDER 1 YEAR	
FEMALE	CAUCASIAN	MONTH DAY YEAR FEBRUARY 11 1948	34 YRS.	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
WASHINGTON, DC	UNITED STATES		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL, NAVAL MEDICAL CMD		HOUSEWIFE		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
MARYLAND	ANARONDA	FT. MEADE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS	
JOSEPH JOHN CHOVANEC		SARAH QUIGLEY		3048-C WADSWORTH COURT FT MEADE, MD. 20755	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		505-60-6413		WILLIAM NELSON GRANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
1749 IMMEDIATE CAUSE (a) _____					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC BREAST CANCER</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 16 DECEMBER 1982, to 18 DECEMBER 1982, that (I) (we) lost saw the deceased alive on 18 DECEMBER 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
R.L. Sollocik MD		DEGREE		19 DEC 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
R.L. SOLLOCIK LEOK/MC		NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814		DEC 23 1982	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12-22-1982		ARLINGTON NAT CEMETARY	
24. FUNERAL DIRECTOR		24a. LOCATION		24b. DATE REC'D. BY REGISTRAR	
CHAMBERS FUNERAL HOME SILVER SPRING, MD.		Arlington, Arlington, Va		DEC 23 1982	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 9 4 REG. NO.			
1. FOR STATE REGISTRAR Margaret Lorraine GRAVEN				2a. DATE OF DEATH MONTH DAY YEAR 12 18 82		2b. HOUR 8:10pm	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 03/24/24		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 11700 Columbia Pike	
14. FATHER'S NAME FIRST MIDDLE LAST Wallace A. Clubb, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marga E. Hancock					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579 20 8495		17. INFORMANT ADDRESS James A. Graven Same as #13 (Husband)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massaging by J. Bled (c) Metastatic Breast Cancer PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: injury							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from From 19 to 12/18/82 , that (I) (we) last saw the deceased alive on 12/16/82 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE H.L. MALTER		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.L. MALTER		22e. ADDRESS 831 University Blvd E. Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G. Maryland	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland				25a. DATE REC'D. BY REG. CLERK DEC 23 1982			

CHRYSLER

Secretary

1924

Secretary

U.S. Government

Secretary

Director

Director

U.S.

Director

Director

U.S.

Director

U.S. GOVERNMENT James A. Garfield, 1900-1908

U.S.

U.S. GOVERNMENT James A. Garfield, 1900-1908
U.S. GOVERNMENT James A. Garfield, 1900-1908
U.S. GOVERNMENT James A. Garfield, 1900-1908

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

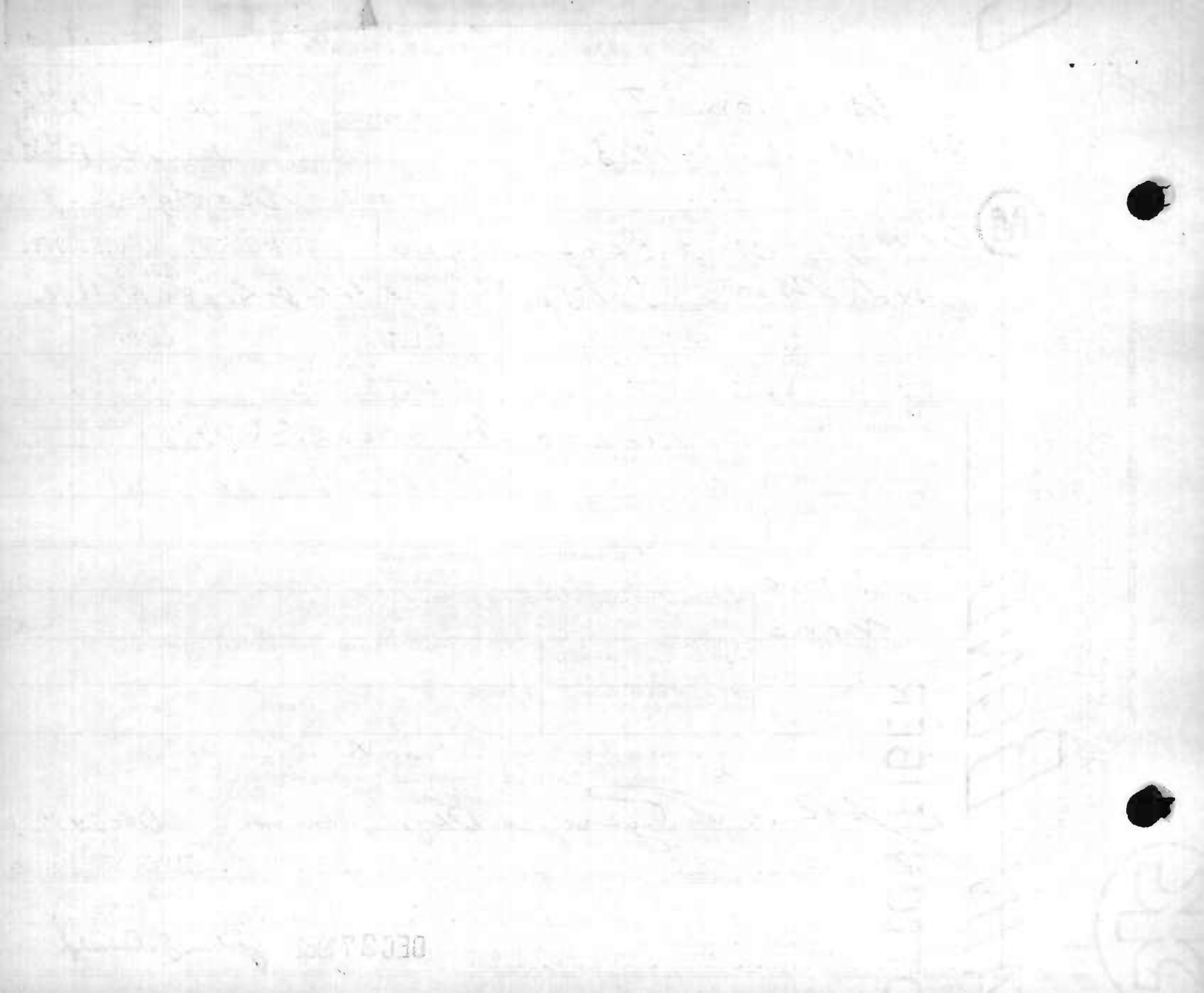
DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>William I Graves Jr.</i>			2a. DATE KNOWN OF DEATH ESTIMATED <i>Dec 24 1982</i>			2b. HOUR <i>4:53 AM</i>		
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>April 24 24 58</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>58 YRS.</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD <i>Dec 24 1982</i>	7d. HOUR <i>4:53 AM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>		
10. CITY OR TOWN OF DEATH <i>Olney</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mont. General Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>VETERANS ADM.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. GOVT.</i>		
13a. STATE <i>MD</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>WILLIAM I. GRAVES, SR.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>LILLIAN CLARK</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>YES</i>		16b. SOCIAL SECURITY NO. <i>WW II 579-07-9705</i>		
17. INFORMANT <i>DAUGHTER</i>		ADDRESS <i>MARGARET L. DIAMOND</i>		18. SAME AS 13 <i>SAME AS 13</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4291 Acute Myocardial Dis</i> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>None</i>								
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <i>Dep.</i>		M.D.		DATE SIGNED <i>Dec 24 1982</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i>		ADDRESS <i>1919 SEMINARY RD., SILVER SPRING, MD.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>12/27/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATIONAL</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>ARLINGTON VIRGINIA</i>		
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>				25a. DATE REC'D BY REGISTRAR <i>DEC 27 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Lough</i>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BILLY JOE JOHNSON GRAY			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-25-82			2b. HOUR 8:50									
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1982		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 8		7. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-25-82							
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			9. CITIZEN OF WHAT COUNTRY? U.S.A.			10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County						
12. CITY OR TOWN OF DEATH Takoma Park			13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital						14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None			15. KIND OF BUSINESS OR INDUSTRY None			
16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland 16b. COUNTY Prince Geo. 16c. CITY OR TOWN Mt. Rainier			17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			18. STREET ADDRESS 3114 Varnum Street #2									
19. FATHER'S NAME FIRST MIDDLE LAST Joseph Gray						20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patricia Johnson									
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NONE OR UNKNOWN) No			22. SOCIAL SECURITY NO. None			23. INFORMANT ADDRESS Joseph A. Gray, Jr. Same as #13 (Father)									
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3229 IMMEDIATE CAUSE (a) Meningitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
25a. DATE OF OPERATION				25b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								26. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
27a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
28a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				28c. LOCATION STREET CITY OR TOWN COUNTY STATE							
29. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Margareta Be Yell				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 12-26-82							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street											
30a. BURIAL, CREMATION, REMOVAL SPECIFY Burial				30b. DATE 12/29/82		30c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				30d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland					
31. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.								32. DATE REC'D. BY REGISTRAR DEC 29 1982						33. REGISTRAR'S SIGNATURE John J. Grier	
34. ADDRESS Hyattsville, Maryland															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 5 9 1			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
Laurie NMN Green				12 22 82			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		2 ^{MONTH} 15 ^{DAY} 1899		83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		USA				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		home		retired U.S. Government			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		20853	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		4811 Arbutus Ave.			
Augusta Green		Lucy Dobson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		578 32 4556		Amos A. Green		4811 Arbutus Ave. Rockville, Md 20853	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							
1539 IMMEDIATE CAUSE (a) CA of colon							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from 12/21 to 12/22, 1982, that (b) (we) lost the deceased alive on 12/21, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) saw the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22c. ADDRESS		22d. DATE SIGNED	
Peter B. Sherer MD				3947 Fernam Dr. Wheaton MD		12/22/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12/24/82		Parklawn Memorial Park		Rockville, Maryland	
24. FUNERAL DIRECTOR (NAME ADDRESS)				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852				DEC 27 1982		John J. Lauer	

BP

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11/11/24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 9 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD S. GREENE				2a. DATE OF DEATH MONTH DAY YEAR Dec 30, 1982		2b. HOUR 1055 A	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 6, 1920		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 62	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never Worked		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward L. Greene				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hope Summers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. Not Available		17. INFORMANT ADDRESS Mary Hope Shiels, Sister, Same as item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Arteriosclerotic myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/30/82 to 12/30/82 , that (1) (we) lost 12/30/82 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.							
22b. SIGNATURE Martin C. Sharpe				DEGREE M.D.		22c. DATE SIGNED 12/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARPE				22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON, MD - 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 3, 1983		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25a. DATE REC'D. BY REGISTRAR JAN 5 1983			
ADDRESS P.A., Rockville, Maryland				REGISTRAR'S SIGNATURE John J. Connel			

BP

EDWARD J. WHELAN
June 30, 1927

Dear Sir:
Enclosed find check for \$100.00

Very truly yours,
E. J. Whelan
12/30/27
12/30/27
12/30/27

50% COTTON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lawrence Henry Greene										2a. DATE KNOWN OF DEATH ESTIMATED 12/23/82	
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 1/18/34	6. AGE (IN YEARS) (LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 12/23/82	2b. HOUR 12:12 P.M.		2d. HOUR 12:12 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Not Available		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 100 W. Montgomery Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Not Available				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1951-1954		16c. SOCIAL SECURITY NO. 232-48-1595		17. INFORMANT ADDRESS Walter Bledsoe, V.A. Officer, 941 N. Capital St., N.E. Wash., D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Coronary arteriosclerosis (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER DATE SIGNED 12-23-82			
EXAMINER'S NAME (TYPE OR PRINT) John Tauber				ADDRESS 8218 Wisconsin Ave.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 3, 1983		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Veterans Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 5 1983				25b. REGISTRAR'S SIGNATURE John J. Lohr			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Rose L. Griffen						2a. DATE OF DEATH MONTH DAY YEAR 12- 29- 82		2b. HOUR 9:15 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 - 05- 22		6. AGE (IN YEARS LAST BIRTHDAY) 60		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST John Robert Dehart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Margaret McComick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Margaret Griffin 12600 Viers Mill Rd. #104 Rockville, Md. 20853							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BREAST CARCINOMA 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19 52 , to DEC. 29, 19 82 , that (I) (we) lost saw the deceased alive on DEC 29, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.											
22b. SIGNATURE Eugene P. Flannery				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 30 DEC 82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene Flannery, M.D.				22e. ADDRESS 18111 PRINCE PHILIP DR OLNEY, MD 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/83		23c. NAME OF CEMETERY OR CREMATORY Laytonsville, Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville Montg. Md.					
24. FUNERAL DIRECTOR Robert H. Sandison 316 E. Diamond Ave. Gartner Sandison F. H. Gaithersburg, Md. 20877				25a. DATE REC'D. BY REGISTRAR JAN 5 1983							
25b. REGISTRAR'S SIGNATURE John J. Connel											

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 0 1

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine P. Griffith			2a. DATE OF DEATH MONTH 12 DAY 21 YEAR 82			2b. HOUR 1055 AM	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH 3 DAY 9 YEAR 1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Herman Wilson Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY at home		13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 301 Russell Ave.		14. FATHER'S NAME FIRST William MIDDLE Plane LAST Brodie		15. MOTHER'S MAIDEN NAME FIRST Catherine MIDDLE Brodie LAST Brodie	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 579-28-5288		17. INFORMANT Judy G. Pindell		ADDRESS 7529 Abbington Dr. Oxon Hill Md/	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Respiratory arrest 4370 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic atrophy DUE TO, OR AS A CONSEQUENCE OF (c) Intestinal occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days years "	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
anxiety

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE OF OPERATION Oct 45 to 12/21/82		21h. DATE OF OPERATION 12/21/82	
22a. I certify that (I) (this hospital) attended the deceased from 12/21/82 to 12/21/82 , that (I) (we) last saw the deceased alive on 12/21/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death)		22b. SIGNATURE Thos G. Ward		DEGREE MD		22c. DATE SIGNED 12/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward		22e. ADDRESS 6116 Robinwood, Bethesda, Md.		22f. ADDRESS 6116 Robinwood, Bethesda, Md.		22g. ADDRESS 6116 Robinwood, Bethesda, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/22/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.	
24. FUNERAL DIRECTOR NAME G.P. Kalas				ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR DEC 27 1982	
				25b. REGISTRAR'S SIGNATURE John J. Canine			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 6 0 2	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ALMA OTTO GROVES					2a. DATE OF DEATH MONTH DAY YEAR Dec. 18, 1982			2b. HOUR 5:35 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 7 1902		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 613 Rosemere Avenue, 20904			
14. FATHER'S NAME FIRST MIDDLE LAST Daniel W. Miffleton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalie Rawlett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT ADDRESS Arthur M. Groves-son-(same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										17 minutes 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Congestive heart failure, Diabetes											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from DEC 5 , 19 82 , to DEC 18 , 19 82 , that (I) (we) lost saw the deceased alive on DEC 18 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Marian Chung				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/18/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIAN CHUNG				22e. ADDRESS 344 University Blvd. W. Silver Spring Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-22-1982		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				11800 N.H. Avenue, Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR DEC 21 1982			
								25b. REGISTRAR'S SIGNATURE J. J. Carver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/82
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Medical Examiner
Cleared by: Dr. Mayle
9

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 2 3 2 6 0 3 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <u>Salvatore Charles Guastella</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>12 30 82</u>			2b. HOUR <u>0910 am</u>	
3. SEX <u>Male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>April 30, 1904</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New Jersey</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD.			
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Shady Grove Adventist Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Accountant</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Con Edison</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Gaithersburg</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>(20874) 13924 Wanegarden Drive</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Vincent Guastella</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Frances Tamburelli</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No</u>				16b. SOCIAL SECURITY NO. <u>066 09 7399</u>		17. INFORMANT ADDRESS <u>13924 Wanegarden Drive</u> <u>Carmen Guastella Gaithersburg, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac pulmonary arrest</u> <u>5307</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastrointestinal bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mallory-Weiss Tears of Stomach</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>a</u>									
19a. DATE OF OPERATION <u>12/19/82</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Uncontrolled Hemorrhage</u>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> , 19 <u>82</u> , to <u>12/20</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12/19/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert A. Varney</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/20/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert A. Varney</u>				22e. ADDRESS <u>9715 Medical Center Dr., Rockville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Dec. 23, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Barnesville Maryland</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</u>				25a. DATE REC'D BY REGISTRAR <u>DEC 27 1982</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP



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Items 4,13a-e,14,15,17 per phone STATE OF MARYLAND
 1. FOR STATE REGISTRAR 1/31/83 dad
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO. 8 2 3 2 6 0 4

1. DECEASED NAME (TYPE OR PRINT) Ralph L. Guernsey			2a. DATE OF DEATH MONTH DAY YEAR 12-22-82		2b. HOUR 9:58 A M		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11-23-30		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Bert Guernsey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathleen (maiden name unknown)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
17. INFORMANT Kathleen		18. ADDRESS 20904		19. STREET ADDRESS 13021 Morningside		20. CITY OR TOWN	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 4310 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive Inter-cerebral bleeding (c) Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE OF DEATH MONTH DAY YEAR 12-22-82		21h. TIME OF DEATH HOUR MIN. SEC. 9:58	

22a. I certify that (a) (this hospital) attended the deceased from 12-22-82 , 19 82 , to 12-22-82 , 19 82 , that (i) (we) lost saw the deceased alive on 12-22-82 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.		22b. SIGNATURE Charles L. Franklin Jr.		22c. DATE SIGNED 20904	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles L. Franklin Jr.		22e. ADDRESS 11120 Waukegan and Silver Spring		22f. CITY OR TOWN Prince Georges	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 23, 82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges Maryland	
24. FUNERAL DIRECTOR NAME W W Chambers Co.		24b. ADDRESS 8655 Georgia Ave.		25a. DATE REC'D. BY REGISTRAR DEC 30 1982		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			8 2 3 2 6 0 5 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR P M
THEODORE BORIS GUSSIN						December 15, 1982			6:15 P M
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		White		February 29, 1928		54 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, DC		USA				Montgomery MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Clinical Center, NIH, Bethesda, Md				Sales Representative		Vaccums	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Prince Geo.		Hyattsville		YES		1903 Ingraham St., 20872	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
William Gussin			Clara Datnov						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes		WW 11-Korean		Alice Gussin (wife) same as patient					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2051 IMMEDIATE CAUSE (a) Cardiopulmonary arrest									2 min.
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia and pulmonary hemorrhage									days
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic myelogenous leukemia									6 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from November 28, 1982, to December 15, 1982, that (we) last saw the deceased alive on December 15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.									
22b. SIGNATURE OF PHYSICIAN						DEGREE		22c. DATE SIGNED	
HENRY MASUR MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/16/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
HENRY MASUR						National Institutes of Health Clinical Center, Bethesda, Md 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			Dec. 21, 1982		Smith Meth. Ch. Cem.		Lumberton, Robeson, N. Car.		
24. FUNERAL DIRECTOR			25. DATE RECD. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Hines, Rinaldi Funeral Home			11800 N.H. Ave., Silver Spring, Md.			DEC 21 1982			

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 2 6 0 6

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BERNICE HALL			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 16, 1982		2b. HOUR 2:52 a M		
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 15 1920		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE TEXAS		13b. COUNTY HARRISON		13c. CITY OR TOWN MARSHALL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST PETE FLETCHER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOU MINNIE HOBBS		16. STREET ADDRESS RT 1, BOX 389			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 454-48-1826		17. INFORMANT ADDRESS WILLIE HALL, RT. 1, BOX 389, MARSHALL, TEXAS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2028 IMMEDIATE CAUSE (a) TRACHIAL BRONCHITIS AND PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MALIGNANT LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 75670
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 19, 1982 , to DECEMBER 16, 1982 , that (I) (we) last saw the deceased alive on DECEMBER 16, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. L. Reed		DEGREE LT, MC, USNR		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 17 Dec 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. L. REED, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12/17/1982		23c. NAME OF CEMETERY OR CREMATORY Shady Grove Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Marshall	
24. FUNERAL DIRECTOR NAME ADDRESS R.N. Horton Co. Morticians 600 Kennedy St. N.W. Washington, DC							

DEC 27 1982 REGISTRAR'S SIGNATURE

NO



2000



CHIEF



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 82 32607				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORA L. HALL					2a. DATE OF DEATH MONTH DAY YEAR 12 8 82		2b. HOUR 1155 AM		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV. 3, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY FREDERICK		13c. CITY OR TOWN MONROVIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3903 OVERLOOK LANE	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES LOCKHART				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAHALIA J. PETERS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 228 50 6153				17. INFORMANT OPAL J. PETERS,		ADDRESS 516 OAK ST. WURLAND, KY.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest + 4151 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Multiple Strokes - Emboli DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Emboli APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 3-5 days 9 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Right Subclavian Artery Emboli									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-29 19 82 to 12-8 19 82 , that (I) (we) lost saw the deceased alive on 12-7 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Douglas R. Shumaker, MD					DEGREE MD		22c. DATE SIGNED 12-8-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas R. Shumaker, MD					22e. ADDRESS 615 W. Montgomery Ave. Rockville MD 20850				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-12-82		23c. NAME OF CEMETERY OR CREMATORY MILLERS CHAPEL		23d. LOCATION CITY OR TOWN COUNTY STATE JONESVILLE, VIRGINIA			
24. FUNERAL DIRECTOR NAME IVES FUNERAL HOME				24b. ADDRESS 2847 WILSON BLVD. ARLINGTON, VIRGINIA		25a. DATE REC'D. BY REGISTRAR DEC 13 1982		25b. REGISTRAR'S SIGNATURE John J. Canine	

BP



RECEIVED
MAY 19 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) George Ray Hammond			2a. DATE OF DEATH Month Day Year Dec. 4, 1982		2b. HOUR A M 5:55
3. SEX Male	4. RACE White	5. DATE OF BIRTH Feb. 22, 1912		6. AGE (In years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wheaton-Manor Care	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Director-Safety	12b. KIND OF BUSINESS OR INDUSTRY AAA		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER # 24 20902 2003 Georgian Way Pl.	
14. FATHER'S NAME First Middle Last UNKNOWN	15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 194-09-2983	17. INFORMANT Address Congord Va. Dr. Lee Anna Mielzarek Yellow Spring, W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>FLUID + ELECTROLYTE IMBALANCE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>WIDESPREAD ADENOCARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>DAYS</u> <u>1 YR.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>80</u> , to <u>12/4</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12/3</u> , 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Richard Delaney, M.D.</u>	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Dec. 6, 1982
22d. PHYSICIAN'S NAME (Type) Richard Delaney, M. D.	22e. ADDRESS 4323 Havard Street, Wheaton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/8/82	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Brentwood Maryland		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>	ADDRESS P.O. Box 7428 Sil. Spr., Md.	25a. REC'D BY REGISTRAR DATE DEC 8 - 1982	25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>		



BP

DHMM - 16 50M 4/82
(VRA 15, 4)

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 3 2 6 0 9			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 12 - 30 - 82			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES H. HARDIE				2b. HOUR 9 P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 - 11 - 27		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONT GOMERY MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.		12a. USUAL OCCUPATION (FOR MOST OF WORKING LIFE) Sales Representative		12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. STATE MD 13b. COUNTY MONTG 13c. CITY OR TOWN ROCKVILLE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS (20852) 10500 ROCKVILLE PIKE	
14. FATHER'S NAME FIRST MIDDLE LAST Augustus Brunner Hardie				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW II				16b. SOCIAL SECURITY NO. 192 20 2060		17. INFORMANT ADDRESS Ruth R. Hardie, same as #13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE (HEPATIC COMA) 5715							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY
DUE TO, OR AS A CONSEQUENCE OF (b) CIRRHOSIS, LIVER							2 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a RENAL FAILURE; CORONARY ARTERY DISEASE; DUODENAL ULCER							
19a. DATE OF OPERATION 10-24-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED HEPATORENAL SYNDROME		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the deceased) attended the deceased from 10/19/82, 19 82, to 12/30/82, 19 82, that (I) (we) last saw the deceased alive on 12/30/82, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alan N. Schulman, MD				DEGREE		22c. DATE SIGNED 12/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN N. SCHULMAN, MD				22e. ADDRESS 9715 MEDICAL CENTER DRIVE ROCKVILLE, MD. 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 3, 1983		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR JAN 5 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

12-20-55
12-20-55

PA - NCA
W. H. E. - 11-27

W. H. E. - 11-27
12-20-55

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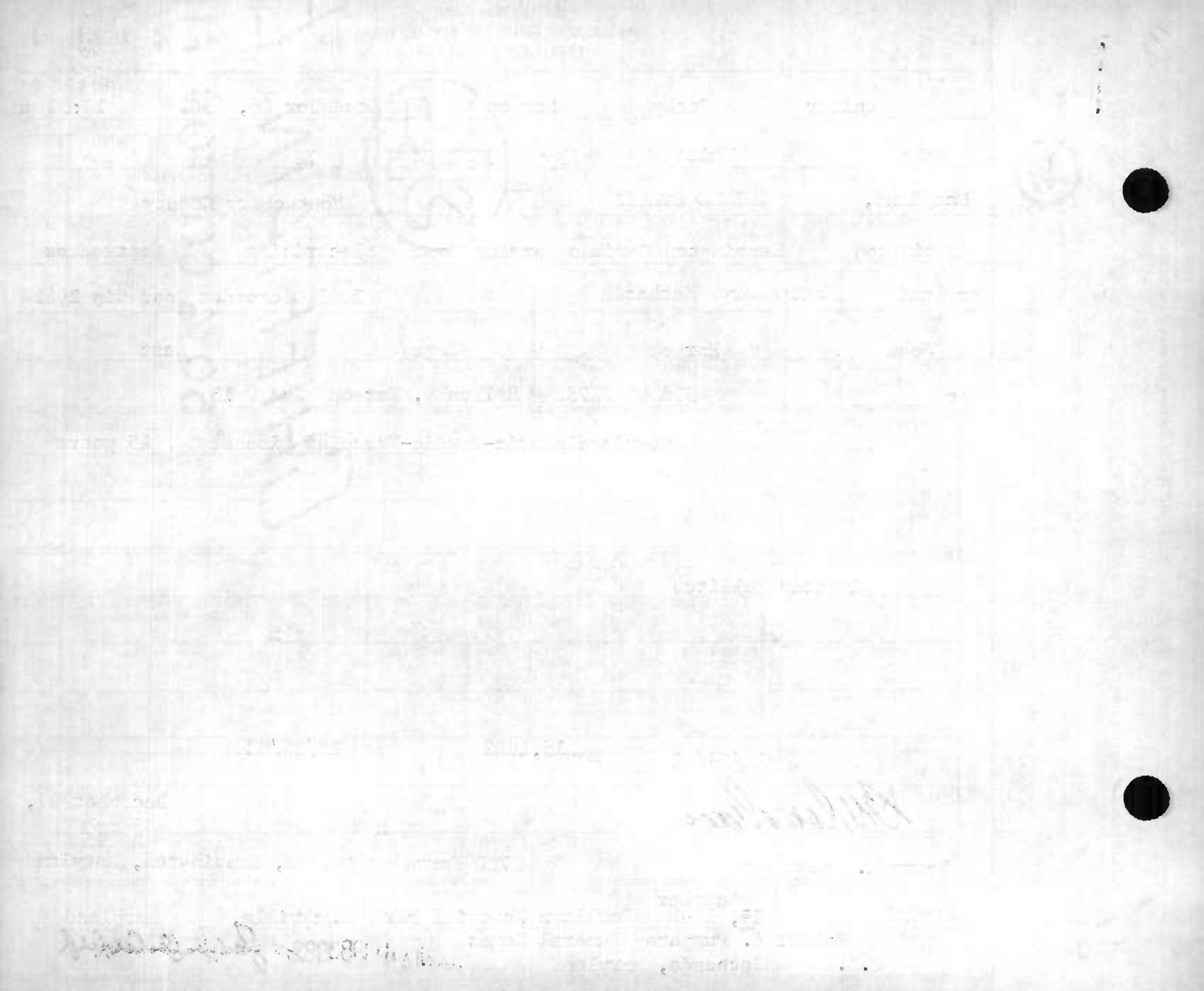
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 3 2 6 1 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Walter Gasby Harmon			2a. DATE OF DEATH MONTH DAY YEAR December 26, 1982		2b. HOUR 10:50 pm	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 13 1904		
6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 78		8. IF UNDER 24 HRS HOURS MIN. 78		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? UNITED STATES		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		
12b. KIND OF BUSINESS OR INDUSTRY Contractor		13a. STREET ADDRESS 7001 Clarendon Road		13b. zip 20814		
14. FATHER'S NAME FIRST MIDDLE LAST John Harmon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Best		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		
16b. SOCIAL SECURITY NO. 578 03 7175A		17. INFORMANT Hellen V. Harmon		18. ADDRESS See # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic-Cardio-Vascular Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from Nov 15, 1982 , 19____, to 12/26/82 , 19____, that (I) (we) lost saw the deceased alive on 12/26/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Barry N. Rosenbaum</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22c. DATE SIGNED December 27, 1982		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry N. Rosenbaum		22e. ADDRESS 3720 Farragut Avenue, Kensington, Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE December 29, 1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland		24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		25a. DATE REC'D BY REGISTRAR 1 JAN 5 1983		
25b. ADDRESS Bethesda, Maryland		25c. REGISTRAR'S SIGNATURE <i>John J. Smith</i>		25d. SIGNATURE <i>John J. Smith</i>		

BP



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) RICHARD J. HARRIDAY					2a. DATE OF DEATH MONTH DAY YEAR DEC. 16, 1982				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		2b. HOUR M	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16 Moore Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 16 Moore Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Jessie Harriday					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myme Diggs				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-01-0354		17. INFORMANT Margaret Frazier		ADDRESS 12630 Veirs Mill Rd. Rockville, Md. 20851			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles Karesch		DEGREE ENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/17/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KARESCH		22e. ADDRESS 6000 PARK DRIVE GAITHERSBURG, MD. 20877							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-21-82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington Street Rockville, Maryland 20850				25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) DEC 23 1982 John J. Conish			

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Don't miss it

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Registrar to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES H. HARRISS					2a DATE OF DEATH MONTH DAY YEAR December 17, 1982		2b HOUR 11:50 pm		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR March 2, 1933		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 49 YRS		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer-Carpenter		12b KIND OF BUSINESS OR INDUSTRY Employed	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 211 Ednor Road (20904)	
14. FATHER'S NAME FIRST MIDDLE LAST Matthew James Harriss					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie May Windsor				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		17 INFORMANT Jane P. Harriss		211 Ednor Road Silver Spring, Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Brainstem bleed DUE TO, OR AS A CONSEQUENCE OF (c) Squamous cell carcinoma CNS CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST 4310 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/10/82 1981									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION —		19b CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. — 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) —					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM ETC.) —		21f LOCATION STREET CITY OR TOWN COUNTY STATE —					
22a I certify that (I) (this hospital) attended the deceased from 11/10 , 19 82 , to 12/17 , 19 82 , that (I) (we) lost saw the deceased alive on 12/17 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b SIGNATURE A. Schenck					DEGREE MD		22c DATE SIGNED 12/18/82		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d PHYSICIAN'S NAME (TYPE OR PRINT) A. Schenck					22e ADDRESS 18111 Prince Philip Dr, Olney, MD				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Dec. 21, 1982		23c NAME OF CEMETERY OR CREMATORY Parklawn Memorial		23d LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND					25a DATE REC'D. BY REGISTRAR DEC 23 1982		25b REGISTRAR'S SIGNATURE John J. Carver		

11:10 PM

November 17, 1955

MEMPHIS

MEMPHIS

TO: SAC, MEMPHIS

FROM: SAC, JACKSON

URGENT

11-17-55 11:10 PM
JACKSON

Dr. John Tauber released this to Dr. Hall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



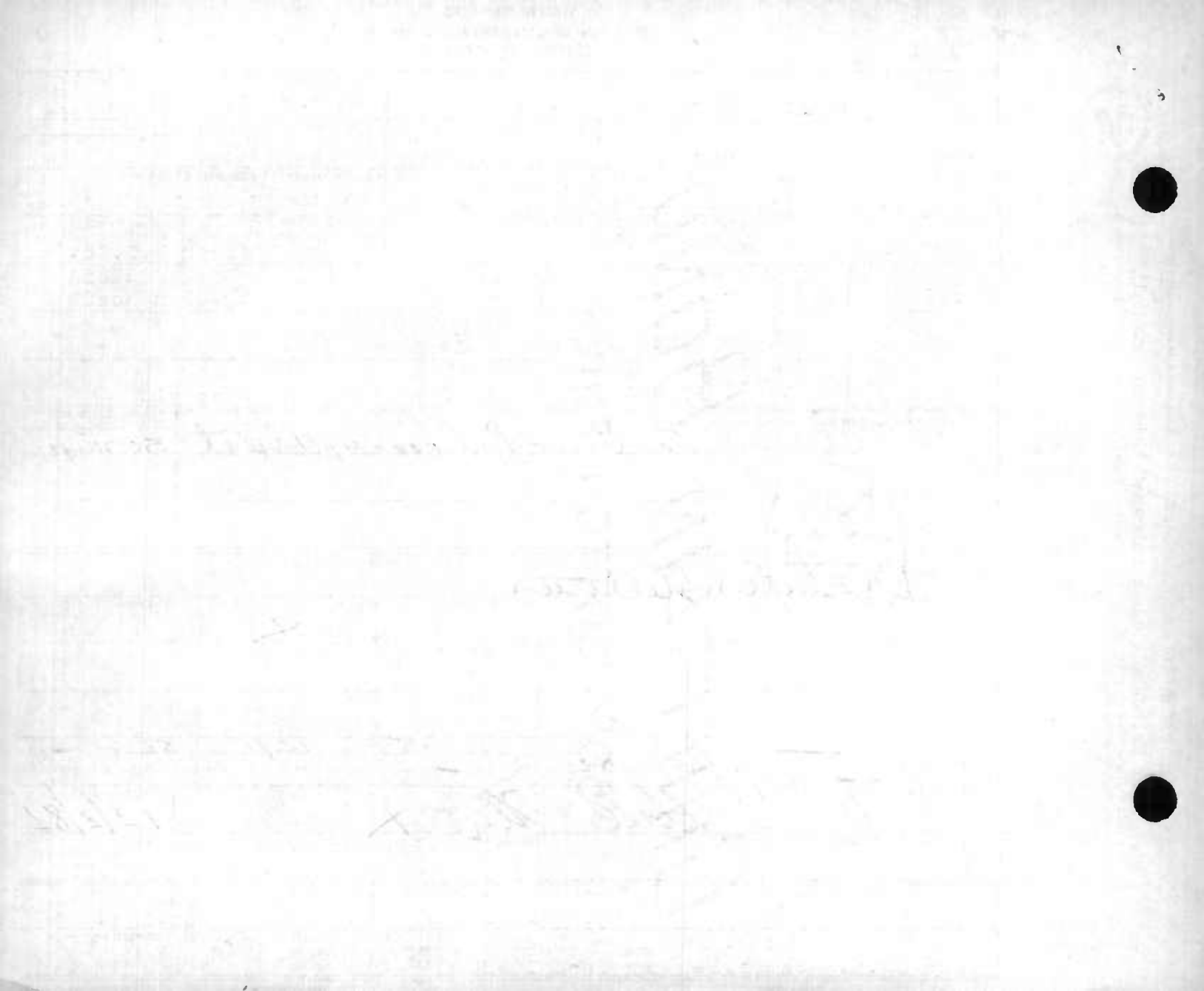
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 1 3

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD Kelly HART			2a. DATE OF DEATH MONTH DAY YEAR December 1, 1982		2b. HOUR 855p M
3. SEX MALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 19, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Safety Officer	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 20854 10004 South Glen Road
14. FATHER'S NAME FIRST MIDDLE LAST Richard K. Hart, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Dyer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Mary Jane Hart, same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac + Pulmonary Arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1983 to 12/11, 1982, that (I) () lost saw the deceased alive on 11/23, 1982, and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () (did not) view the body after death.					
22b. SIGNATURE W. J. Hall		DEGREE M.D.		22c. DATE SIGNED 12/2/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William G. Hall, M.D.		22e. ADDRESS 615 West Montgomery Avenue Rockville, Maryland 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 4, 1982	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850		25a. DATE REC'D. BY REGISTRAR DEC 6 - 1982		25b. REGISTRAR'S SIGNATURE John J. Bauer	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 2 3 2 6 1 4			
1. FOR STATE REGISTRAR								
1. DECEASED NAME (TYPE OR PRINT) Nellie R. Haskin					2a. DATE OF DEATH MONTH DAY YEAR December 5, 1982			2b. HOUR 2:30 A
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11TH 28 '93		6. AGE (IN YEARS LAST BIRTHDAY) 89		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa N. Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9109 St. Andrew Place
14. FATHER'S NAME FIRST MIDDLE LAST James Carlick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Brown			16. SOCIAL SECURITY NO. 577 18 7609			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		17. INFORMANT Nancy Zabel (Daughter)			17a. ADDRESS 9109 St. Andrew Place, College Pk., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Coronary heart disease DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis heart disease DUE TO, OR AS A CONSEQUENCE OF (c) hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Alcohol								
19a. DATE OF OPERATION 11-12-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 1-15-81 , to 12-6-82 , that (I) (the) last saw the deceased alive on 11-12-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.								
22b. SIGNATURE Seruch T. Kimble		DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-6-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Seruch T. Kimble, MD		22e. ADDRESS 9801 Georgia Ave. S.S. Md.						
23a. BURIAL, CREMATION, REMOVAL (Type) Burial		23b. DATE 12/7/82		23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.		
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 N.H. Ave. S.S. Md.					25a. DATE REC'D. BY REGISTRAR DEC 7 - 1982		25b. REGISTRAR'S SIGNATURE John J. Connel	

Cleared by Dr. John Rogers, Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO. 8 2 3 2 6 1 5				
1. DECEASED NAME (TYPE OR PRINT) William Calvin Hatton					2a. DATE OF DEATH MONTH DAY YEAR Dec. 15, 1982			2b. HOUR 10:58p M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1936		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp., Silver Spr, Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Trucking Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md. 20782		13b. CITY OR TOWN Prince Georges		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3515 Madison Street			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Calvin Hatton					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy V. Braden				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (BY OR FOR DATES) Korean 229 36 0821		17. INFORMANT ADDRESS Elizabeth E. Hatton Same as #13 (Wife)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary hemorrhage 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma lung DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hrs 4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1979 to Dec 15 , 19 82 , that (I) (we) last saw the deceased alive on Dec 15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hubert J. Alpert M.D.					22c. DATE SIGNED 15 DEC 82			22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT J. ALPERT, MD	
22e. ADDRESS 8630 FENTON ST. SILVER SPRING, MD 20910									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/18/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Md.						25a. DATE REC'D. BY REGISTRAR DEC 21 1982		25b. REGISTRAR'S SIGNATURE John J. Calver	

MEDICAL CERTIFICATION

CONFIDENTIAL - SECURITY INFORMATION



Virginia

U.S.A.

X

Feb. 17, 1978

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Calvin

Jan. 12, 1982

10-020

Yes	Korean	020 36 0821	Elizabeth E. Patton	Same as #17 (file)	
Joseph	Calvin	Patton	Dorothy	V.	Barton
Prince	George	Lyttleville			7317 Madison Street
Al. 20782					
Silver Spring	Illy Cross Hosp.	Silver Spr Md	Truck Driver	Trucking Co.	

Lyttleville, Md.
Patricia Goch's funeral home, P.A.
10/10/82

10/10/82

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 2 3 2 6 1 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL BRAGUNIER HAYDEN			2a. DATE OF DEATH MONTH DAY YEAR 12/22/82		2b. HOUR / 1 AM M	
3. SEX F	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR APRIL 13, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHURCH SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 11277 COLUMBIA PIKE 20901	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BRAGUNIER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE SELENA UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 578-03-3159		17. INFORMANT ADDRESS ANN H. GOULD SAME AS 13 DAUGHTER		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4/100

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) **arteriosclerotic heart disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**6 days****2 weeks**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 75 to 12/22 19 82 , that (I) (we) last saw the deceased alive on 12/21 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Israel Spector MD				DEGREE		22c. DATE SIGNED 12/22/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Israel SPECTOR MD				22e. ADDRESS 12001 Ferrara Ave Wheaton Md 20906			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/24/82	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION (CITY OR TOWN) COUNTY STATE ARLINGTON VIRGINIA
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR DEC 27 1982 25b. REGISTRAR'S SIGNATURE John J. Connelley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Item #166 per phone call w/Fun. Home 1. STATE REGISTRAR FOR 12/7/82 rc DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 8 2 3 2 6 1 7					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances Charlotte Heiges		2a. DATE OF DEATH MONTH DAY YEAR Dec, 7, 1982		2b. HOUR 6A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 4, 1906	
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15015 Flower Valley Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Mont. 13b. COUNTY 13c. CITY OR TOWN Rockville					
14. FATHER'S NAME FIRST MIDDLE LAST Michael Cuatt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janette Gifford			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Dr. Lynwood Heiges (Husband) Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD with cardiac arrhythmia and acute CHF 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Dec. 4, 1982, to Dec. 7, 1982, that (I) (we) last saw the deceased alive on Nov. 23, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE Frederick Mooman, M.D.		22c. DATE SIGNED 12-7-82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick Mooman	
22e. ADDRESS 18111 Pr. Philip Dr. Olney, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/9/82		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Spencer, New York					
24. FUNERAL DIRECTOR Hines, Rinaldi 11800 N.H. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR DEC 7 - 1982		25b. REGISTRAR'S SIGNATURE John J. Carver	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURNED TO YOU FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND										8 2 3 2 6 1 8	
DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <i>M. H. Henry</i>										2a. DATE KNOWN OF DEATH ESTIMATED <i>Dec 13 1982</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>Aug 14 1949</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>93</i> YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD <i>Dec 13 1982</i>		2d. HOUR <i>130</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery, MD</i>					
10. CITY OR TOWN OF DEATH <i>Sr. L. Spg</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>340 Glen Eagles Dr Apt 3F</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>ASST. STATION MASTER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>WASH TERM.</i>			
13a. STATE <i>MD</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Sr. L. Spg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>340 Glen Eagles Dr Apt 3F</i>			
14. FATHER'S NAME FIRST <i>WILLIAM</i> MIDDLE <i>FRANKLIN</i> LAST <i>HENRY</i>				15. MOTHER'S MAIDEN NAME FIRST <i>MARY</i> MIDDLE <i>ALICE</i> LAST <i>CRAWFORD</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>718-14-9608</i>		17. INFORMANT <i>DAUGHTER IN LAW</i> ADDRESS <i>1702 WHITE OAK DR SILVER SPRING, MD. 20910</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: <i>4291 Acute Myocardial Infarction</i>											
IMMEDIATE CAUSE (a) <i>4291</i>											
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<i>None</i>											
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <i>M.D.</i>				DATE SIGNED <i>Dec 13/1982</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i>				ADDRESS <i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>12/16/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PROSPECT HILL CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>WASHINGTON, D. C.</i>					
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 17 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Grier</i>					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

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RECEIVED BY THE
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.

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RECEIVED BY THE
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.

Cleared by Med Examiner (Rogers)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 8 2 3 2 6 1 9					
1. DECEASED NAME (TYPE OR PRINT) ^{last} DORIS J. HOFMANN ^{first} DORIS					2a. DATE OF DEATH MONTH DAY YEAR 12-12-82 2b. HOUR 10 ⁴⁵ AM					
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR MARCH 27 ^R , 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp., Silv Spr Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND					13b. CITY OR TOWN SILVER SPRING		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 10800 GEORGIA AVENUE 20902	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES JENKINS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 577-10-7115		17. INFORMANT SON ADDRESS PAUL W. HOFMANN, JR. SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100. Acute Myocardial Infarction, hrs DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary Artery Disease yrs DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. _____										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) a.k.				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I (this hospital) attended the deceased from 12/11/82 to 12/12/82, that (1) (we) last saw the deceased alive on 12/11/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Alan I. Kermaier, MD						22c. DEGREE MD		22d. DATE SIGNED 12/12/82		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN I. KERMAIER, MD						22f. ADDRESS 9801 GEORGIA AVE SS MD 20902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/15/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION SILVER SPRING COUNTY MONT STATE MD.			
24. FUNERAL DIRECTOR FRANCIS J. COLLINS NAME 500 UNIV. BLVD., W., SILVER SPRING, MD.						25a. DATE REC'D. BY REGISTRAR DEC 17 1982 REGISTRAR'S SIGNATURE John J. Conner				

CLEARED BY DR ROGERS, MEDICAL EXAMINER

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DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Fannie M. Hofstetter					2a. DATE OF DEATH MONTH DAY YEAR Dec. 27, 1982			2b. HOUR 9:43pm	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept 14, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland Montgomery Kensington					13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 9916 Thornwood Road 20895		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Peters					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Lester				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. B 216 03 0154		17. INFORMANT ADDRESS 9916 Thornwood Road Kensington daughter, Margaret Musgrove Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) ATHEROSCLEROSIS, GENERAL AND CEREBRAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) WITH SENILE DEMENTIA & STROKES DUE TO, OR AS A CONSEQUENCE OF (c) AND RESP. ARREST (TERMINAL)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS YEARS 1 Hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OSTEOPOROSIS, GENERALIZED.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 6 , 19 68 , to 12/27 , 19 82 , that (1) (we) lost saw the deceased alive on 12/27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.									
22b. SIGNATURE James A. Roberts, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. ROBERTS, MD.				22e. ADDRESS 8907 GEORGIA AVE. SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25. DATE RECEIVED BY REGISTRAR JAN 5 1983 REGISTRAR SIGNATURE John J. Smith					

RECEIVED - U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

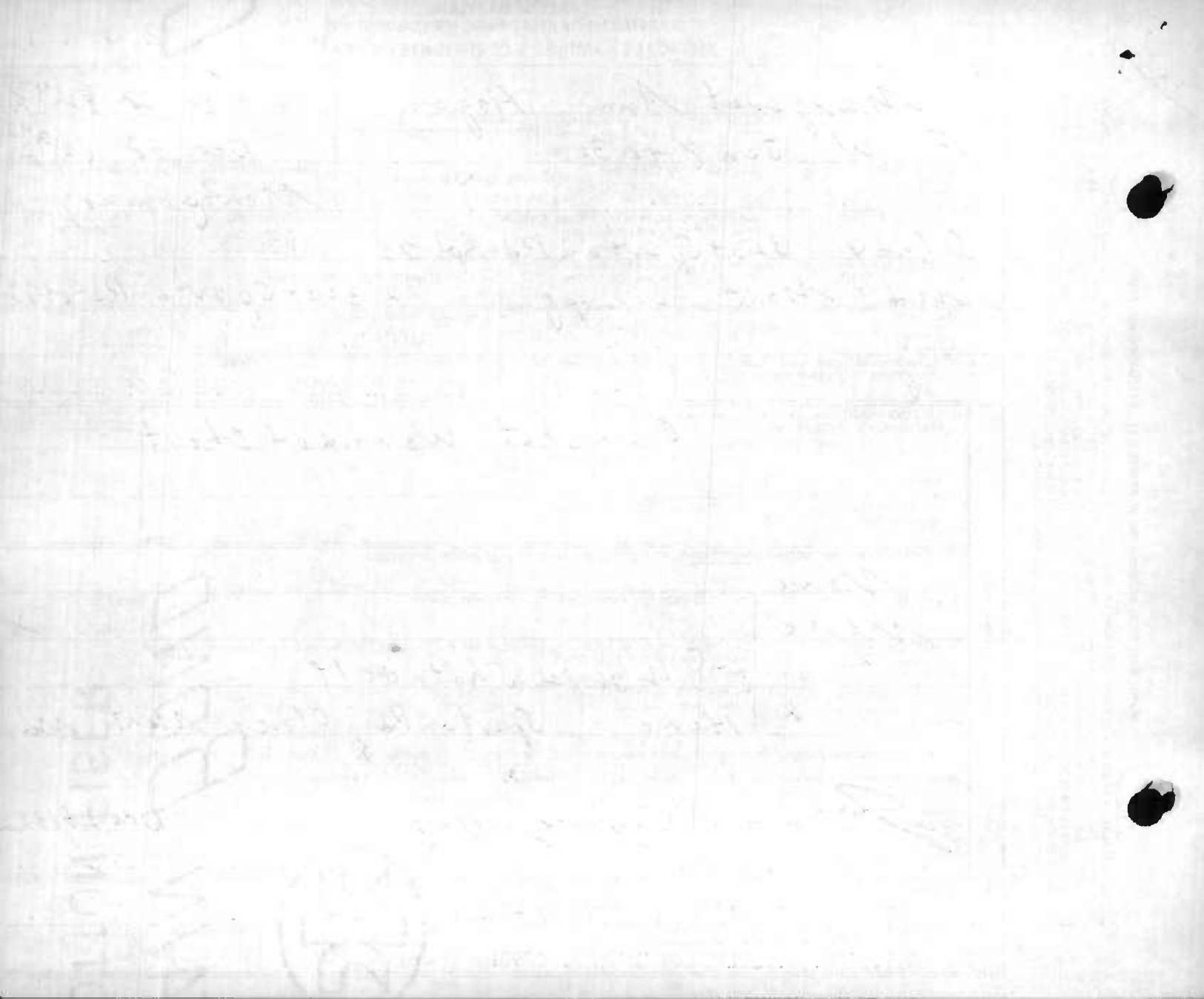
RECEIVED - U.S. DEPARTMENT OF JUSTICE

2-13-68
Feb 13 1968
Investigator
FBI
Silver Spring
Hoxly Cross Hospital
Montgomery
0016 Thompson Road
001-443-8377

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 6 2 1	
1. DECEASED NAME (TYPE OR PRINT) Margaret Ann Hogan										2a. DATE KNOWN OF DEATH Dec. 28 1982	
3. SEX F	4. RACE W	5. DATE OF BIRTH (MONTH DAY YEAR) Jan 8 46	6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Dec. 28 1982		2b. HOUR 9 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3234 Spartan Rd Apt 72				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3234 Spartan Rd Apt 72			
14. FATHER'S NAME (FIRST MIDDLE LAST) RALPH MASTERS				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) MARGARET COLLINS				20832			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-44-4399		17. INFORMANT WILLIAM K. HOGAN		ADDRESS SAME AS 13 HUSBAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Punchshot Wound of chest 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH gun 12 30 1982		21b. TIME OF INJURY (HOUR AM MONTH DAY YEAR) 12 30 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot self							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION (CITY OR TOWN STREET) Spartan Rd Olney		COUNTY Mont.		STATE MD.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D. Dep.				MEDICAL EXAMINER		DATE SIGNED Dec 28 1982			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS		ADDRESS 1919 SEMINARY RD., SILVER SPRING, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/31/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION (CITY OR TOWN) SILVER SPRING		COUNTY MONT STATE MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR JAN 6 1983		25b. REGISTRAR'S SIGNATURE John J. Collins			
ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 2 2

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Ann C. Holmes		2a. DATE OF DEATH MONTH DAY YEAR Dec. 13, 1982	
3. SEX Female		2b. HOUR 805 M	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 87	
5. DATE OF BIRTH MONTH DAY YEAR July 23 rd 1895		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
7b. CITIZEN OF WHAT COUNTRY? USA		12b. KIND OF BUSINESS OR INDUSTRY Retired	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Gov't		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
13a. STATE Md.		13b. COUNTY Mont.	
13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3465 Chiswick Court		14. FATHER'S NAME FIRST MIDDLE LAST Joseph W. Clarke	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Redman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) None	
16b. SOCIAL SECURITY NO. 334 18 2089A		17. INFORMANT ADDRESS Maryland Nat. Doris Scherf(Excutive) Bank	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Carcinoma of colon = DUE TO, OR AS A CONSEQUENCE OF metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF Diffuse Sepsis due to trauma (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. DATE SIGNED 13 Dec 82	
22a. I certify that (I) (this hospital) attended the deceased from 2 July 19 81, to 13 Dec 19 82, and that (I) (we) lost saw the deceased alive on 13 Dec 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Gustavo S. Belaval MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Gustavo S. Belaval		22d. ADDRESS Leisure World Medical Center Silver Spring, Md. 20906	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/ /82	
23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Wash. D.C.	
24. FUNERAL DIRECTOR Hines, Rinaldi 11800 N.H. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR DEC 16 1982	
25b. REGISTRAR'S SIGNATURE John J. Carver			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 2 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MORDECAI HOSEH			2a. DATE OF DEATH MONTH DAY YEAR 12 20 92			2b. HOUR 8³⁰ AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR MAY 9, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3280 Glen Eagles Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHEMIST (RET)	
12b. KIND OF BUSINESS OR INDUSTRY RESEARCH/EDIT.							
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3280 Glen Eagles Drive (20906)				
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 418-18-0877		17. INFORMANT ADDRESS Maryland 20784 OSCAR KURTZ:6640 Adrian Street;New Carrollton			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

2080 IMMEDIATE CAUSE (a) **Acute Leukemia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Two

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

Zollinger Ellison Syndrome

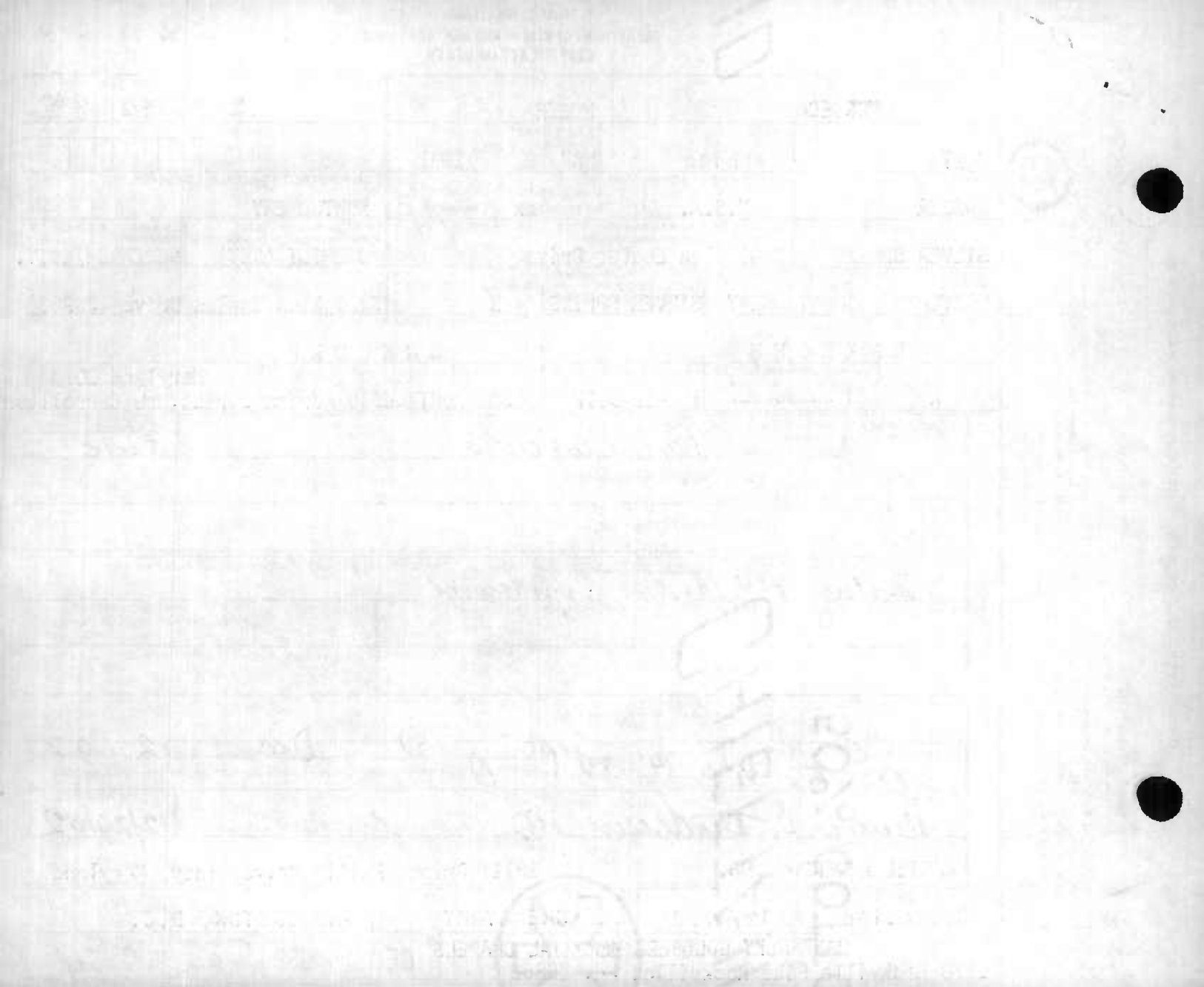
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 81 to Dec 82 , that (I) (we) last saw the deceased alive on Dec 14 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Daniel L. Anderson MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ANDERSON, MD.				22e. ADDRESS 18111 Prince Philip Drive; Olney, Maryland			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/22/82		23c. NAME OF CEMETERY OR CREMATORY LEE CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG, MEMORIAL CHAPELS				25a. DATE REC'D. BY REGISTRAR DEC 27 1982			
1170 Rockville Pike; Rockville, Md. 20852				25b. REGISTRAR'S SIGNATURE John J. Canfield			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



RETURNED TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

RETURNED TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8 2 3 2 6 2 4											
1. DECEASED NAME (TYPE OR PRINT) Ethel E. Howard				2a. DATE OF DEATH MONTH DAY YEAR 12 16 82				2b. HOUR p. m. 1:00			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9 3 1912		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1029 Quince Orchard Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY sales			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1029 Quince Orchard Rd. 2087			
14. FATHER'S NAME FIRST MIDDLE LAST Clarence E. Mills				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Reed							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 48 3152A		17. INFORMANT ADDRESS Bethesda, Md. 20816 Lois H. Clatterbuck 6409 Dahlonga Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK 1539 DUE TO, OR AS A CONSEQUENCE OF (b) BILIARY OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF (c) CANCER OF COLON										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HRS 3 MOS 9 MOS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 1, 19 82 to DECEMBER 16, 19 82 , that (I) (we) last saw the deceased alive on DECEMBER 1, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Linda D. Green md DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Linda D. Green, M.D.				22e. ADDRESS 2121 Pennsylvania Ave. N.W. Wash. D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/20/82		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Maryland					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR DEC 23 1982 25b. REGISTRAR'S SIGNATURE John J. Lohr					

HOWARD

Ind

Montgomery

1059 1000 1000 1000



1000



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 6 2 5			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM LINWOOD HOYLE JR				2a. DATE OF DEATH MONTH DAY YEAR DEC 12 1982			
3. SEX MALE				2b. HOUR 11 45 AM			
4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV 28, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 81		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH KENSINGTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3613 FARRAGUT AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISPATCHER		12b. KIND OF BUSINESS OR INDUSTRY LUMBER/FUEL COMPANY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN KENSINGTON 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 3613 FARRAGUT AVENUE 20895			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM L. HOYLE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JONES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-03-8095		17. INFORMANT SON ADDRESS 1132 PIPE STEM PLACE ROCKVILLE, MD. 20854			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Colon Cancer DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Spread Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 Months 4 months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12 PM 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from FEB 11 19 82 to 12 PM 19 82 that (I) (we) last saw the deceased alive on 29 NOV 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eugene P. Libre MD DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12 Dec 82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBRE MD				22e. ADDRESS 10400 CONNECTICUT AVE KENSINGTON MD. 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/15/82		23c. NAME OF CEMETERY OR CREMATORY ST ROSE OF LIMA		23d. LOCATION CITY OR TOWN COUNTY STATE GAITHERSBURG MONT MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR DEC 17 1982 25b. REGISTRAR'S SIGNATURE John J. Connel			

BP

585 71 030

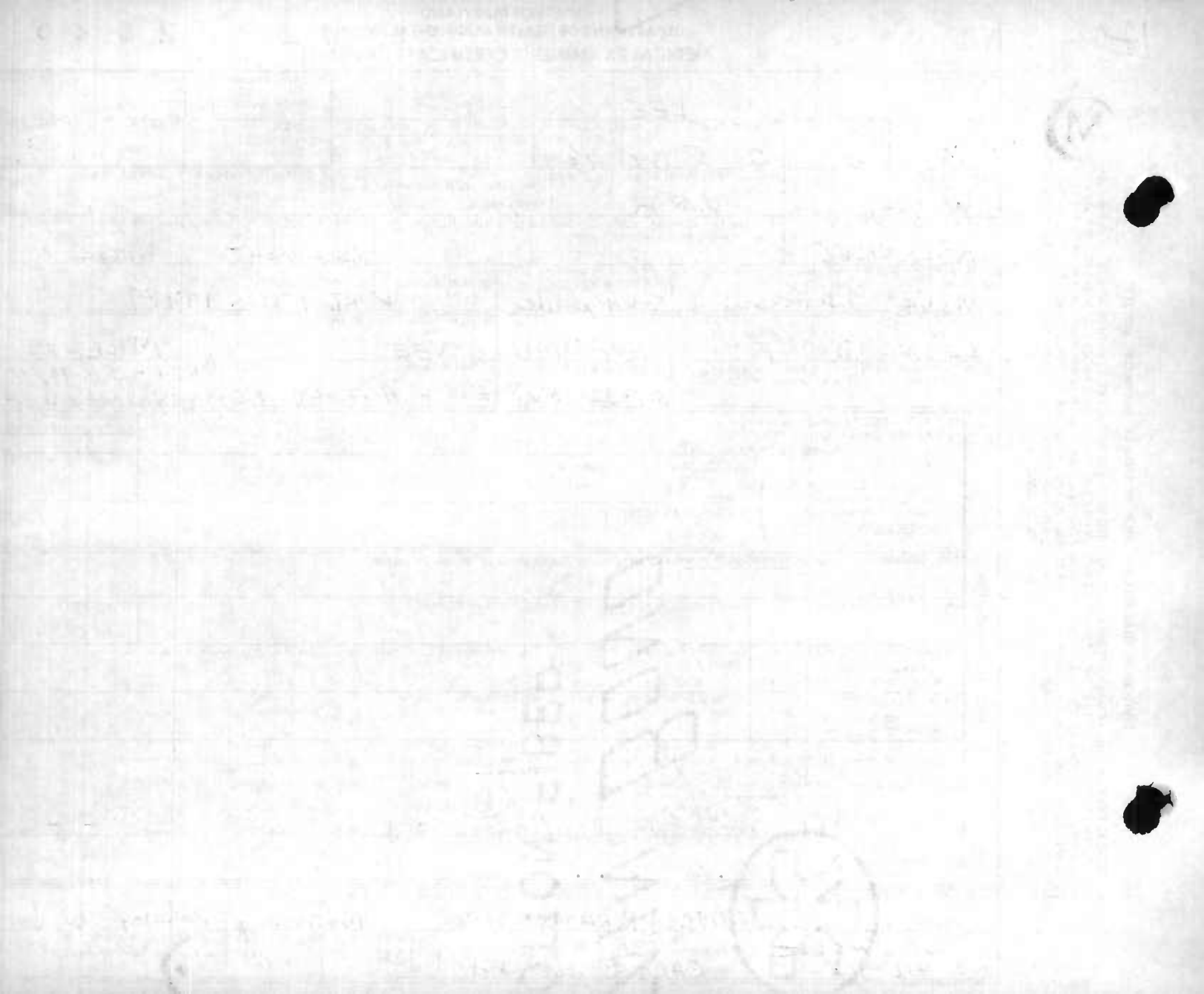
2017

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. RETURN ALL PAGES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 2 6 2 6			
1- STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David LEE Huffman							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 29 19 82		2b. HOUR M				
3 SEX M		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2 5 1936		6. AGE (IN YEARS) LAST BIRTHDAY 46 YRS.		7c. DATE PRONOUNCED DEAD 12 29 19 82		2d. HOUR 2:57 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GOVERNMENT		12b. KIND OF BUSINESS OR INDUSTRY NSSC			
13a. STATE W. VA.				13b. COUNTY JEFFERSON		13c. CITY OR TOWN KEARNEYSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT. 1 BOX 177F7			
14. FATHER'S NAME FIRST MIDDLE LAST LEONARD F. HUFFMAN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VEE MILLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 317-32-1568		17. INFORMANT EDITH HUFFMAN				ADDRESS RT. 1 - BOX 177F7 KEARNEYSVILLE, W. VA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 12-30-82	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/2/1983		23c. NAME OF CEMETERY OR CREMATORY PLEASANT VIEW				23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg Berkeley W. VA.			
24. FUNERAL DIRECTOR NAME W.C. HILTON				ADDRESS Box 86 BARNESVILLE, Md.				25a. DATE REC'D. BY REGISTRAR JAN 5 1983				REGISTRAR'S SIGNATURE John E. Lander	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 6 2 7			
FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Joseph - F. Hunter				MONTH DAY YEAR 12-19-82			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1912		2b. HOUR 4:35 P.M.	
6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cuba		7b. CITIZEN OF WHAT COUNTRY? USA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Section Supervisor Central P.O. Personnel Office			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Washington Adventist Hospital		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Montgomery			
13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Hunter, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Henry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes. WW11				16b. SOCIAL SECURITY NO. 579-38-8472			
17. INFORMANT H. Foster Hunter-brother-S.S. Md.				ADDRESS 11355 Columbia Pike 20904			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (c) 1629							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/22, 1982, to 12/19, 1982, that (I) (we) lost saw the deceased alive on 12/17, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE HCO LO B... MD				DEGREE MD		22c. DATE SIGNED 12/20/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIRKLAND C. BREWER				22e. ADDRESS 1600 Columbia Ave Takoma Park, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-23-1982		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Georges Md.	
24. FUNERAL DIRECTOR NAME HAYES/RONALDI				Funeral Home SS 11800 NEW HAMP. S.S. MD.		25a. DATE REC'D. BY REGISTRAR DEC 21 1982	
				25b. REGISTRAR'S SIGNATURE J. and J. Carver			

88-09041

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
ALEX		HYATT		12-3-82		10:45		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR	
Male		WHITE		JULY 10 1904		78		MONTHS DAYS HOURS MIN.	
7c. BIRTH PLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
LITHUANIA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville MD		HEBREW HOME OF GREATER WASHINGTON		RABBI		CLERGY			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD		Montgomery		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8705 EASTERN AVENUE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?					
MORRIS		HYATT		LEAH		WEINSTEIN WEST		16a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH					
389-46-6577		RABBI JULIUS HYATT		18a. IMMEDIATE CAUSE (a) Cardiorespiratory Arrest					
				18b. DUE TO, OR AS A CONSEQUENCE OF (b) Uremia					
				18c. DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY?									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH									
21b. TIME OF INJURY									
21c. HOW INJURY OCCURRED									
21d. INJURY OCCURRED									
21e. PLACE OF INJURY									
21f. LOCATION									
22a. I certify that (I) (this hospital) attended the deceased from Aug. 27, 1981, to Dec 3, 1982, that (I) (we) last saw the deceased alive on Dec 3, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE									
22c. DATE SIGNED									
22d. PHYSICIAN'S NAME									
22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL									
23b. DATE									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION									
24. FUNERAL DIRECTOR									
25a. DATE REC'D. BY REGISTRAR									
REGISTRAR'S SIGNATURE									



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 2 9

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bessie Mae Ireland			2a. DATE OF DEATH MONTH DAY YEAR 12/21/82		2b. HOUR 12 ²⁵ P M	
3. SEX female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 12, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Household
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		13b. COUNTY AACo.	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3677 18t. Ave.
14. FATHER'S NAME FIRST MIDDLE LAST William Baskerville			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Pague			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 420-03-4467		17. INFORMANT Dorothy Farren		ADDRESS Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

4408

IMMEDIATE CAUSE (a)

cardiac arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

immed

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

arteriosclerotic vascular disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

carcinoma of the breast with metastasis 1981

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the undersigned) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Walter E. Goozh		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-21-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD				22e. ADDRESS 2309 SHOREFIELD RD LOHEATON MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-22-82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Co. Md.	
24. FUNERAL DIRECTOR NAME Hardesty				ADDRESS Annapolis Md.		25a. DATE REC'D. BY REGISTRAR DEC 23 1982	
REGISTRAR'S SIGNATURE John J. Canfield							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be filed on a separate form.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		2b. HOUR	
ELIZABETH NELL JACKSON						NOVEMBER 29 1982		5:45 ^a _m	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		CAUCASIAN		JULY 3 1929		57 53 YRS.		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
ARKANSAS		UNITED STATES				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		NAVAL HOSPITAL				HOUSEWIFE		OWN HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
VIRGINIA		LOUDOUN		STERLING		1705 N. ARGONNE AVENUE			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
AARON JEROME AULT				MAMIE MAY REYNOLDS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				266-32-0728		WILLIE F. JACKSON, 1705 N. ARGONNE AVENUE,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
1830 IMMEDIATE CAUSE (a) RESPIRATORY ARREST									
DUE TO, OR AS A CONSEQUENCE OF									
(b) END STAGE OVARIAN CARCINOMA									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 24, 19 82, to NOVEMBER 29, 19 82, that (I) (we) last saw the deceased alive on NOVEMBER 29, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.									
22b. SIGNATURE		22c. DATE SIGNED							
CHARLES TATUM, LT, MC, USNR		11-29-82							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL		DEC. 2, 1982		CHESTNUT GROVE CEM.		HERNDON		FAIRFAX VA	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			
J. BERKLEY GREEN, 721 ELDEN ST., HERNDON, VA						DEC 2 1982			

NY 100-100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical examiner must be present at the funeral home.

Cleared by Medical Examiner

DR. JOHN TAUBER 12/6/82

Item #500 Per phone call w/Fun. STATE OF MARYLAND
 1- FOR Home 12/21/82 rc DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 REGISTRAR CERTIFICATE OF DEATH

REG. NO. 8 2 3 2 6 3 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FANNIE -- JAFFE		2a. DATE OF DEATH MONTH DAY YEAR 12 5 82		2b. HOUR 4:15 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR July 5, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN CITY, GIVE STREET ADDRESS) BETHESDA RETIREMENT NSG. HM.		12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. STATE MD.		13b. CITY OR TOWN MONTGOMERY SILV. SPR.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 11215 OAKLEAF DR.
14. FATHER'S NAME FIRST MIDDLE LAST JACOB -- KUPER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST --- UNKNOWN ---		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-40-6927		17. INFORMANT 7026 MARY CASSATT DR. DR. ALFRED JAFFE POTOMAC, MD.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: CARDIRESPIRATORY ARREST IMMEDIATE CAUSE (a) 4275 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/5, 19 82 to 12/5, 19 82, that (I) (we) lost saw the deceased alive on NEVER 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.				
22b. SIGNATURE Carol Bender for V.B. Fitzgerald		22c. DATE SIGNED		22d. ADDRESS 11510 OLD GEORGETOWN RD. ROCKVILLE MD.
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. CAROL BENDER		22f. ADDRESS 11510 OLD GEORGETOWN RD. ROCKVILLE MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/7/82		23c. NAME OF CEMETERY OR CREMATORY BETH SHOLOM CEMETERY CAPITAL HTS. MARYLAND
23d. LOCATION CITY OR TOWN COUNTY 1170 ROCKVILLE PK. ROCKVILLE MD.		23e. DATE OF REG'D BY REGISTRAR DEC 10 1982		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM CHP, INC.				



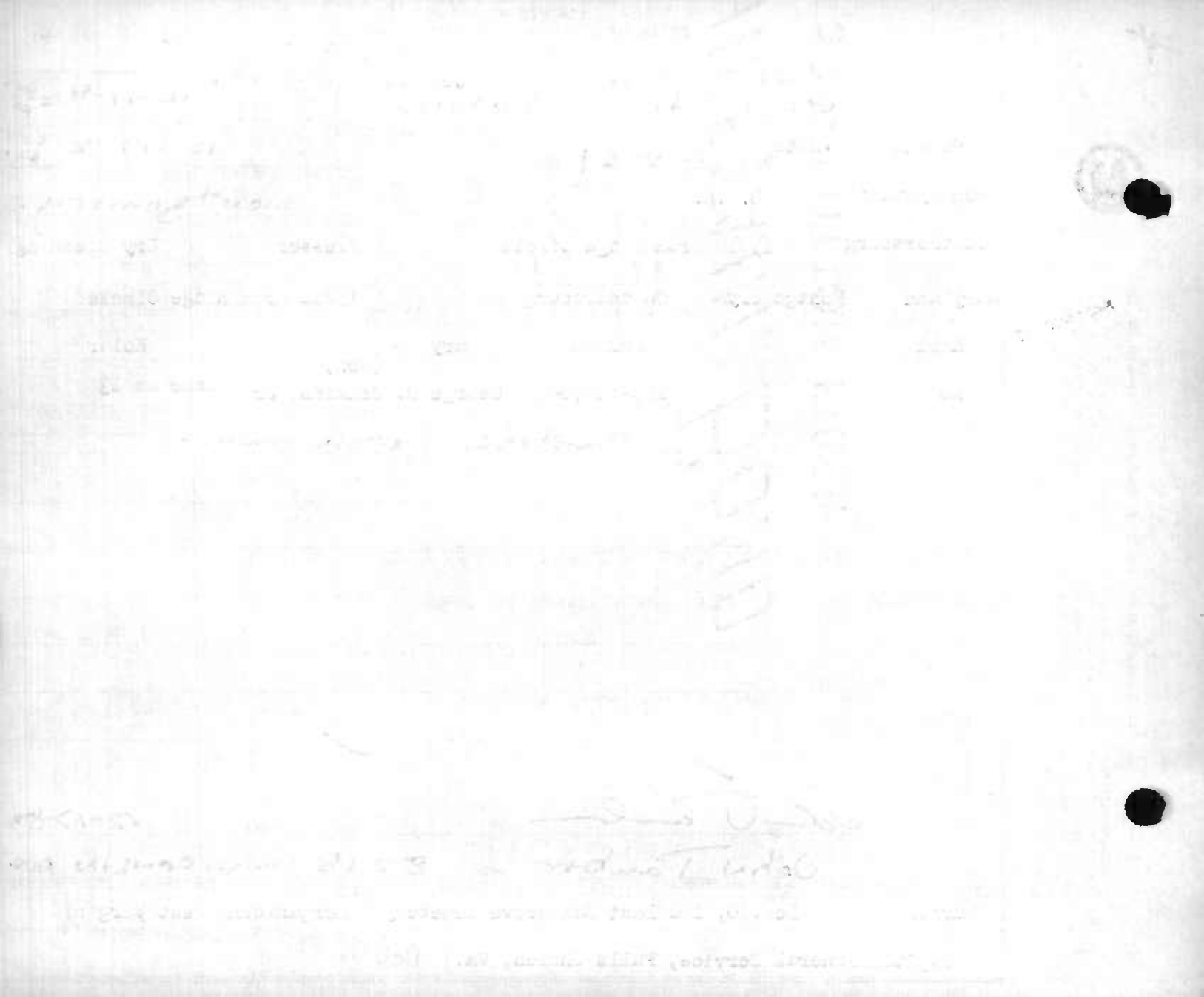
100% COTTON 4-18-19



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 6 3 2	
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Sara</u> MIDDLE <u>F.</u> LAST <u>Jenkins</u>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <u>12</u> DAY <u>17</u> YEAR <u>82</u>		2b. HOUR <u>2:30</u> P.M.			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>2</u> DAY <u>2</u> YEAR <u>13 69</u> YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN.		7c. DATE PRONOUNCED DEAD MONTH <u>12</u> DAY <u>17</u> YEAR <u>82</u>		2d. HOUR <u>2:30</u> P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.		
10. CITY OR TOWN OF DEATH <u>Gaithersburg</u>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>19212 Drum Ridge Circle</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Presser</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Dry Cleaning</u>	
13a. STATE <u>Maryland</u>						13b. CITY OR TOWN <u>Montgomery</u>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <u>19212 Drum Ridge Circle</u>	
14. FATHER'S NAME FIRST <u>Karl</u> MIDDLE <u></u> LAST <u>Furman</u>						15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u></u> LAST <u>Kolar</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>			(IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. <u>190-10-7806</u>		17. INFORMANT (son) <u>George R. Jenkins, Jr.</u>		ADDRESS <u>Same as 13</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>1519</u> IMMEDIATE CAUSE (a) <u>Gastric Carcinoma -</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John Tauber</u> M.D.						TITLE (SPECIFY) _____			DATE SIGNED <u>12-17-82</u>		
EXAMINER'S NAME (TYPE OR PRINT) <u>John Tauber</u>						ADDRESS <u>8218 WISCONSIN AVE</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>Dec. 20, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Oak Grove Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Morgantown, West Virginia</u> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <u>Capitol Funeral Service, Falls Church, Va.</u> ADDRESS						25a. DATE REC'D BY REGISTRAR <u>DEC 23 1982</u> REGISTRAR'S SIGNATURE <u>George R. Jenkins, Jr.</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. STATE REGISTRAR					8 2 3 2 6 3 3					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR					
FIRST MIDDLE LAST <i>Harold WILLIAM Johnson</i>					2b. HOUR <i>10:56pm</i>					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		
<i>Male</i>		<i>CAUCASIAN</i>		<i>JULY 24, 1907</i>		<i>75</i> YRS.		<i>10:56pm</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>PENNSYLVANIA</i>		<i>U.S.A.</i>				<i>Montgomery</i> MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
<i>Silver Spring</i>		<i>Holy Cross Hospital</i>				<i>RETIRED</i>		<i>U.S. GOVT.</i>		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<i>MARYLAND</i>					<i>MONTGOMERY</i>		<i>SILVER SPRING</i>		<i>11718 KINGTREE STREET 20902</i>	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
<i>ANDREW W. JOHNSON</i>					<i>ANNA CAROLINE HERMANSON</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
<i>YES</i>					<i>WW II</i>		<i>GRACE M. JOHNSON SAME AS 13 WIFE</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>1991</i> IMMEDIATE CAUSE (a) <i>Exacerbated undifferentiated carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF <i>carcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>12/30/82</i> to <i>12/30/82</i> , that (I/we) lost saw the deceased alive on <i>12/30/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Barry N. Rosenbaum, M.D.</i>					DEGREE		22c. DATE SIGNED <i>12/31/82</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BARRY N. ROSENBAUM</i>					22e. ADDRESS <i>3720 FARRAGUT AVE. KENSINGTON, MD. 20895</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
<i>CREMATION</i>			<i>1/3/83</i>		<i>METROPOLITAN CREMATORY</i>		<i>ALEXANDRIA VIRGINIA</i>			
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>					25a. DATE REC'D. BY REGISTRAR <i>JAN 6 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John L. Carver</i>			

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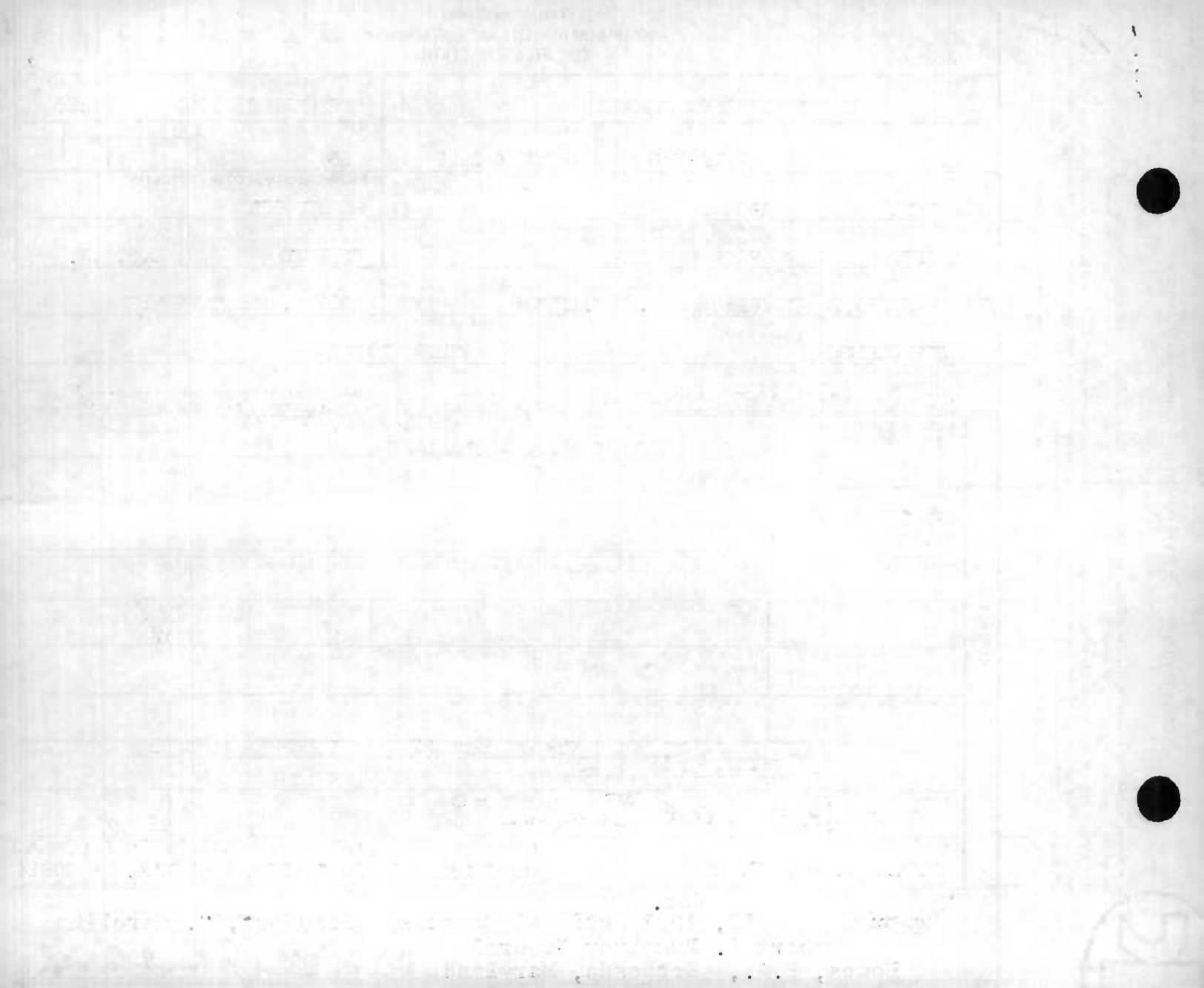
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 2 3 2 6 3 4									
1. DECEASED NAME (TYPE OR PRINT) JOSEPH CARLETON JOHNSON						2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 15 1982		2b. HOUR 9:05 a.m.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 4 1927		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE SOUTH CAROLINA 13b. COUNTY CHARLESTON 13c. CITY OR TOWN N. CHARLESTON				13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS 1002 S. RHETT AVENUE			
14. FATHER'S NAME FIRST MIDDLE LAST JOE JOHNSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EIHEL CHAFFIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1945-1967		17. INFORMANT FANNIE JO JOHNSON		ADDRESS 1002 S. RHETT AVENUE,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 12^m 1982 , to DECEMBER 15 1982 , that (I) (we) lost saw the deceased alive on DECEMBER 15 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H.L. REED DEGREE MD						22c. DATE SIGNED 15 DEC 1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.L. REED, LT, MC, USNR						22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE Dec. 17, 1982		23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Beaufort, S. Carolina			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey						25a. DATE REC'D. BY REGISTRAR DEC 20 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.						8 2 3 2 6 3 5	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Mabel		MIDDLE S.		LAST Johnson		2a. DATE OF DEATH MONTH DAY YEAR	
Mabel S. Johnson								12 23 82	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		Sept. 18, 1901		81		9 ⁰² M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
So. Carolina		USA				Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Rockville, MD		Shady Grove Adv. Hospital						Clerk - AEC	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
US Gov't.		Md. 20841		Montgomery		Boys		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Frederick W.H. Scady		Margaret Ann Bowey		No		250-01-5384		Margaret S. Johnson, Same address as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Myocardial Infarction						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4100								Days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Coronary Atherosclerosis						years	
		(c) Generalized Atherosclerosis						years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
Hypertension, Diabetes Mellitus, Renal Insufficiency									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec 16, 1982, to Dec 23, 1982, that (I) (we) lost									
saw the deceased alive on Dec 22, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (we) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
Harris K. Kenner, MD		MD				12/23/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
HARRIS K. KENNER, MD		10401 Old Georgetown Rd Bethesda, Maryland 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		12/24/82		Cedar Hill Crematory		Suitland, Maryland			
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR (25) REGISTRAR'S SIGNATURE							
Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016		DEC 28 1982							

BP

Mr. S. B. H.	White	Sept. 18, 1901	Johnson
So. Carolina	USA	X	Montgomery
Mr. S. B. H.	White	Sept. 18, 1901	Johnson
So. Carolina	USA	X	Montgomery
Mr. S. B. H.	White	Sept. 18, 1901	Johnson
So. Carolina	USA	X	Montgomery
Mr. S. B. H.	White	Sept. 18, 1901	Johnson
So. Carolina	USA	X	Montgomery
Mr. S. B. H.	White	Sept. 18, 1901	Johnson
So. Carolina	USA	X	Montgomery

Bedford, Maryland

John Hill Gregory

12/24/02

Oranston

2150 Leominster Ave., N. W., Washington, D. C. 20008
 Joseph M. Hill, Inc.
 12/24/02

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 3 6

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Julius JONTIFF			2a. DATE OF DEATH MONTH DAY YEAR DEC. 29 1982			2b. HOUR 3²⁵ P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 15 03		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PARKING ATTENDANT		12b. KIND OF BUSINESS OR INDUSTRY SAVING & LOAN	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND		13b. CITY OR TOWN MONTGOMERY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 8712 COLESVILLE ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST STIMON JONTIFF				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH ESTHER COHEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 578-09-8061		17. INFORMANT 9 TAPIOLA COURT HENRY JONTIFF, ROCKVILLE, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2028 Pneumonia IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Lymphoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/1/80 , 19 82 , to 12/29/82 , 19 82 , that (I) (we) last saw the deceased alive on 12/29 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mark H. EUG				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				22c. DATE SIGNED 12/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK H. EUG, M.D.				22e. ADDRESS 9801 Georgia Avenue Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/31/1982		23c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CONGREGATION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.			
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR JAN 4 1983		25b. REGISTRAR'S SIGNATURE John J. Carroll			
25c. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.									

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1

MEDICAL CERTIFICATION

29

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

101 WHITE LIGHT

25.00 per 1000
1000 = 25.00

1000 = 25.00

1000 = 25.00

1000 = 25.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 6 3 7 REG. NO.			
1. DECEASED NAME (PRINT) Frances D. Jordan				2a. DATE OF DEATH MONTH DAY YEAR 12-16-82			
3. SEX Female				4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR December 16, 1920	
6. AGE (IN YEARS LAST BIRTHDAY) 62		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistician				12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't			
13a. STATE Maryland				13b. COUNTY Mont.		13c. CITY OR TOWN Sil Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Willard F. Davis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ola Mae Scott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 252-22-4373		17. INFORMANT ADDRESS Claudia Davis Bivins, Sis. S.E. Wash., DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Multiple Myeloma 2030 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes, Hypertension, Neuropathy, old Brain Tumor							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from May 19 80, to Dec 16 19 82, that (we) lost saw the deceased alive on 12/16/82, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Peter Sherer MD				DEGREE MD		22c. DATE SIGNED 12/17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 3947 Ferrara Dr. Wheaton MD				22e. ADDRESS PETER SHERER MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE Dec. 21, 1982		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE Atlanta, Georgia	
24. FUNERAL DIRECTOR NAME McGuire Funeral Service, Inc.		4740 Georgia Ave. NW Washington, D.C. 20012		25. DATE REC'D BY REGISTRAR AND REGISTRAR'S SIGNATURE DEC 23 1982 John J. Smith			

BP

1. The first of the
principal factors
in the determination
of the results of the
census is the quality of the
enumeration.

2. The second factor is the
accuracy of the
enumeration.

3. The third factor is the
completeness of the
enumeration.

4. The fourth factor is the
consistency of the
enumeration.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 4/72
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
8 2 3 2 6 3 8 CERTIFICATE OF DEATH										
REG. NO.										
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT) Dorothy Elaine Joyce					December 23, 1982					
3. SEX Female					7b. HOUR 3:15p					
4. RACE White					M					
5. DATE OF BIRTH Nov. 24, 1924					6. AGE (IN YEARS LAST BIRTHDAY) 58					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 7020 Barkwater Ct. 20817					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator					12b. KIND OF BUSINESS OR INDUSTRY Psychiatric center					
13a. STATE Maryland					13b. COUNTY Montgomery					
13c. CITY OR TOWN Bethesda					13d. INSIDE CITY LIMITS? YES					
14. FATHER'S NAME Homer Prock					15. MOTHER'S MAIDEN NAME Lena Ernest					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No					16b. SOCIAL SECURITY NO. 449-30-8497					
17. INFORMANT Mr. Christopher R. Joyce (son)					ADDRESS 323 Severn Rd Epping Forest Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Liver failure										
1830 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic ovarian carcinoma										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) ?/5 years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 6, 1981 , to Dec. 6, 1982 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 6, 1982 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.										
22b. SIGNATURE MARC LIPPMAN			DEGREE MD			22c. DATE SIGNED 12-23-82		22d. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/24/82			23c. NAME OF CEMETERY OR CREMATORY Metropolitan			23d. LOCATION Alexandria Fairfax Virginia	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852						25a. DATE REC'D. BY REGISTRAR DEC 30 1982		25b. REGISTRAR'S SIGNATURE John J. Smith		

THE UNIVERSITY OF CHICAGO
LIBRARY

Board of Trustees
Chicago, Illinois
January 1, 1900

To the Board of Trustees
of the University of Chicago

I have the honor to acknowledge the receipt of your letter of the 27th inst.

and in reply to inform you that the same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,

James H. Thompson
Secretary

Very truly,
Yours,
James H. Thompson

Enclosed for the Board of Trustees
is a copy of the report of the

Committee on the proposed
amendment to the

constitution of the University of Chicago.

I am, Sir, very respectfully,
Your obedient servant,

James H. Thompson
Secretary

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Yours,
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James H. Thompson
Secretary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 6 3 9	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MARY Katherine KANE						2a. DATE OF DEATH MONTH 12 DAY 16 YEAR 82		2b. HOUR 10 MIN 30 AM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH 9 DAY 19 YEAR 96		6. AGE (IN YEARS LAST BIRTHDAY) 86		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. STATE MD		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN BELTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4104 Steeplechase Dr. 20705			
14. FATHER'S NAME FIRST George MIDDLE - LAST Willeke				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Elizabeth LAST Ruppert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO 578-62-0940		17. INFORMANT Mary T. Hartman ADDRESS Daughter Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia 4360 DUE TO, OR AS A CONSEQUENCE OF (b) - DUE TO, OR AS A CONSEQUENCE OF (c) - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease with congestive failure.											
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR - - 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) -							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET - CITY OR TOWN - COUNTY - STATE -							
22a. I certify that (I) (this hospital) attended the deceased from Nov 22 19 96 , to Dec 16 19 82 , that (I) (we) last saw the deceased alive on Dec 14 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) <input checked="" type="checkbox"/> did <input type="checkbox"/> did not view the body after death.											
22b. SIGNATURE William F. Simpson MD						22c. DATE SIGNED 12/16/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. Simpson MD						22e. ADDRESS 8106 NH Ave. Silver Spring Md 20903					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 18, 1982		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN Washington, D.C. COUNTY - STATE -					
24. FUNERAL DIRECTOR Francis J. Collins ADDRESS 500 University Blvd., W. Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR DEC 27 1982 REGISTRAR'S SIGNATURE Sam J. Canfield					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

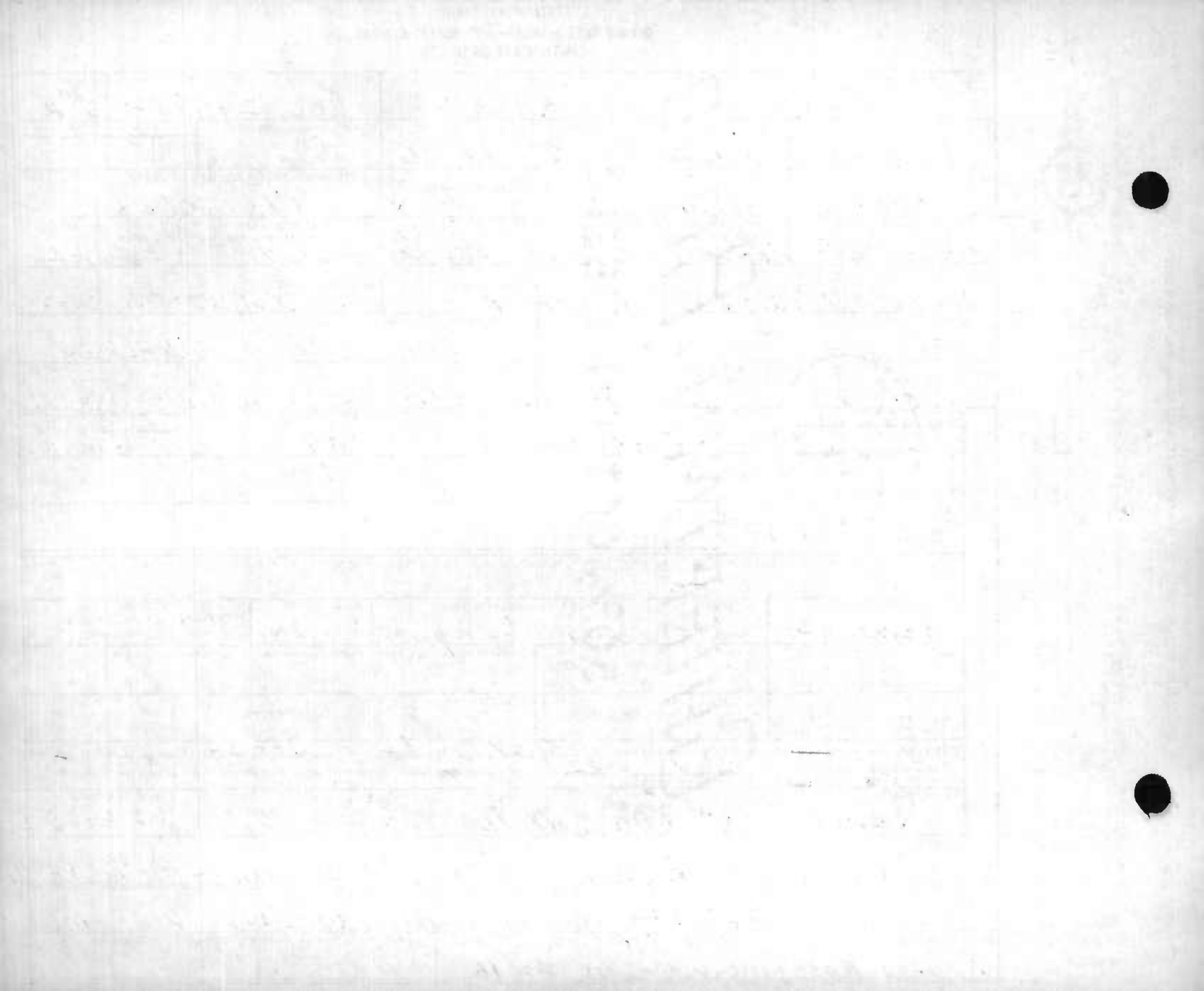
IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 4 0

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MARY MIDDLE LAST KATRIS		MONTH DAY YEAR	
3. SEX		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		76 YRS.	
4. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
WHITE		8 MONTH DAY YEAR 8 18 06	
5. DATE OF BIRTH		9. BALTIMORE CITY OR COUNTY OF DEATH	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		MONTHS DAYS HOURS MIN.	
PENNSY.		76	
7b. CITIZEN OF WHAT COUNTRY?		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
U.S.		SECY.	
10. CITY OR TOWN OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		LEGAL	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STREET ADDRESS	
16520 PERSIMMON TREE		241 W. HUDSON ST.	
13a. CITY OR TOWN		13b. INSIDE CITY LIMITS?	
LONG BEACH		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST JOSEPH HOFF		FIRST MIDDLE LAST MARY LOUISE WALKER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
NO		113-18-578	
17. INFORMANT		ADDRESS	
CAROL WHITNEY		16701 WISC. AVE MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		6 mos.	
1629 IMMEDIATE CAUSE (a) Carcinoma Lung			
DUE TO, OR AS A CONSEQUENCE OF			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
June 82		Carcinoma Lung	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			
P.M. 19			
21d. INJURY OCCURRED		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
22a. I certify that (I) (this hospital) attended the deceased from Oct 19 82, to Dec 24 19 82 that (I) (we) last saw the deceased alive on Nov 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
James W. Egan M.D.		12.24.82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
James W. Egan		5413 Cedar Lane - Bethesda, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
CREMATION		12/26/82	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Cedar Hill Crematory		CITY OR TOWN COUNTY STATE	
3800 MACOMB ST., N.W.		SUITLAND P.G. MD	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D BY REGISTRAR	
RICHARD RAPP, INC., WASH. DC. 20046		DEC 28 1982	
		25b. REGISTRAR'S SIGNATURE	
		John J. Lohr	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 6 4 1			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) M. Amanda KERSHNER					2a. DATE OF DEATH MONTH DAY YEAR 12/27/82					2b. HOUR 1:15 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 23 1912			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Artist-Illustrator		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20901 11457 Lockwood Dr. Apt. #1		
14. FATHER'S NAME FIRST MIDDLE LAST William B. Brown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Roe								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS 224-S.E. 7th St. Gainesville, Fla. 32601						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Superior Vena Cava Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3 weeks 5 years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic obstructive lung disease													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1975 , 19____, to 12/27/82 , 19____, that (I) (we) last saw the deceased alive on 12/26/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Jeremy V. Cooke					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 12/28/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cooke					22e. ADDRESS 10400 Conn Ave Kensington								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 12/29/82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.				
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.					P.O. Box 7428 ADDRESS Sil. Spr., Md.			25a. DATE REC'D. BY REGISTRAR DEC 29 1982		25b. REGISTRAR'S SIGNATURE John J. Canick			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS ANTICIPATED. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGES 1, 2, AND 3 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST John		MIDDLE C		LAST Killeen		2a. DATE OF DEATH		KNOWN ESTIMATED 12 24 19 82		2b. HOUR 11 07 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 16 18		6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 12 24 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec.	
13a. STATE MASS.		13b. COUNTY -		13c. CITY OR TOWN WORCHESTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 281 BURNING ST		14. FATHER'S NAME FIRST MIDDLE LAST John J. Killeen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Sullivan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) W.W. 11		16b. SOCIAL SECURITY NO. 071-09-7108		17. INFORMANT John J. Killeen (Son)		ADDRESS 1537 15th St. N.W.		Wash. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) CORONARY ARTEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE Yrs													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 10 30 P.M. 12 24 1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED AT HOME					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9807 BRIDGEMAN RD POTOMAC MARYLAND					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Francis C Mayo				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER				DATE SIGNED	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 28, 1982				23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Worcester Maryland Mass.	
24. FUNERAL DIRECTOR NAME Jos. Gawler's Sons 5130 Wisc. Ave N.W. Washington D.C.								25a. DATE REC'D. BY REGISTRAR DEC 29 1982		25b. REGISTRAR'S SIGNATURE John J. Canine			

Page.

U.S.A.

Hospital

Excess

Postal Station

John

J.

Killian

Julia

William

Yes

W.V. 11

01-00-1108

John J. Killian (son)

1737 1st St. N.W.
Wash. D.C.

Postal

Dec. 28, 1985 St. John's Cemetery

Washington

Mass.

Jon. Gawler's Sons FIVE
Washington D.C.

DEC 28 1985
John J. Killian

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 6 4 3	
1. DECEASED NAME (TYPE OR PRINT) Sr. Mary Marguerite Viola Klein C.S.C.							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR Dec. 6, 1982		2b. HOUR 8:20 A.M.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH (MONTH DAY YEAR) Sept. 22, '12		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Dec. 6 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5000 Strathmore Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Religious Nun		12b. KIND OF BUSINESS OR INDUSTRY Teacher			
13a. STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5000 Strathmore Avenue	
14. FATHER'S NAME (FIRST MIDDLE LAST) John Klein				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Mary Gegg							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 140-42-6782		17. INFORMANT ADDRESS Sr. Maureen Patrice O'Keefe-Superior same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Rheumatoid arthritis and Parkinson's Disease											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John F. Tauber				TITLE (SPECIFY) _____				M.D. _____		MEDICAL EXAMINER DATE SIGNED 12-6-82	
EXAMINER'S NAME (TYPE OR PRINT) John F. Tauber				ADDRESS 8218 Wisconsin Avenue Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/9/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN Washington COUNTY D.C. STATE D.C.			
24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 University Blvd. W., Silver Spring, Maryland						25a. DATE REC'D. BY REGISTRAR DEC 9 1982 REGISTRAR'S SIGNATURE John F. Tauber					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAPERS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 401 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32644	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. DATE ESTI- MATED	
GEORGE		N.		KOKINOS		KOKINOS		12-11-82		19	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN	
MALE		CAUCASIAN		JULY 10, 1935		47 RS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. DATE PRONOUNCED DEAD		11. MONTH DAY YEAR	
PENNSYLVANIA		U.S.A.				Montgomery County		12-11-82		19	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. DATE OF DEATH		14. HOUR MIN	
Silver Spring		Holy Cross Hospital		SUPERVISOR		U.S. LIFE CORP.				4:11P	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		14. HOUR MIN	
MARYLAND		MONTGOMERY		SILVER SPRING		YES		10401 CONOVER DRIVE 20902			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS	
NESTOR		KOKINOS		YES		188-26-5986		MELBA Y. KOKINOS		SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) and fibrosis of liver DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23a. BIRTHAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		23c. NAME OF CEMETERY OR CREMATORY		BURIAL		12/17/82	
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE		27. DATE OF DEATH		GATE OF HEAVEN		12/17/82	
FRANCIS J. COLLINS		DEC 17 1982		John J. Conick		12-13-82		SILVER SPRING		MONT MD.	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

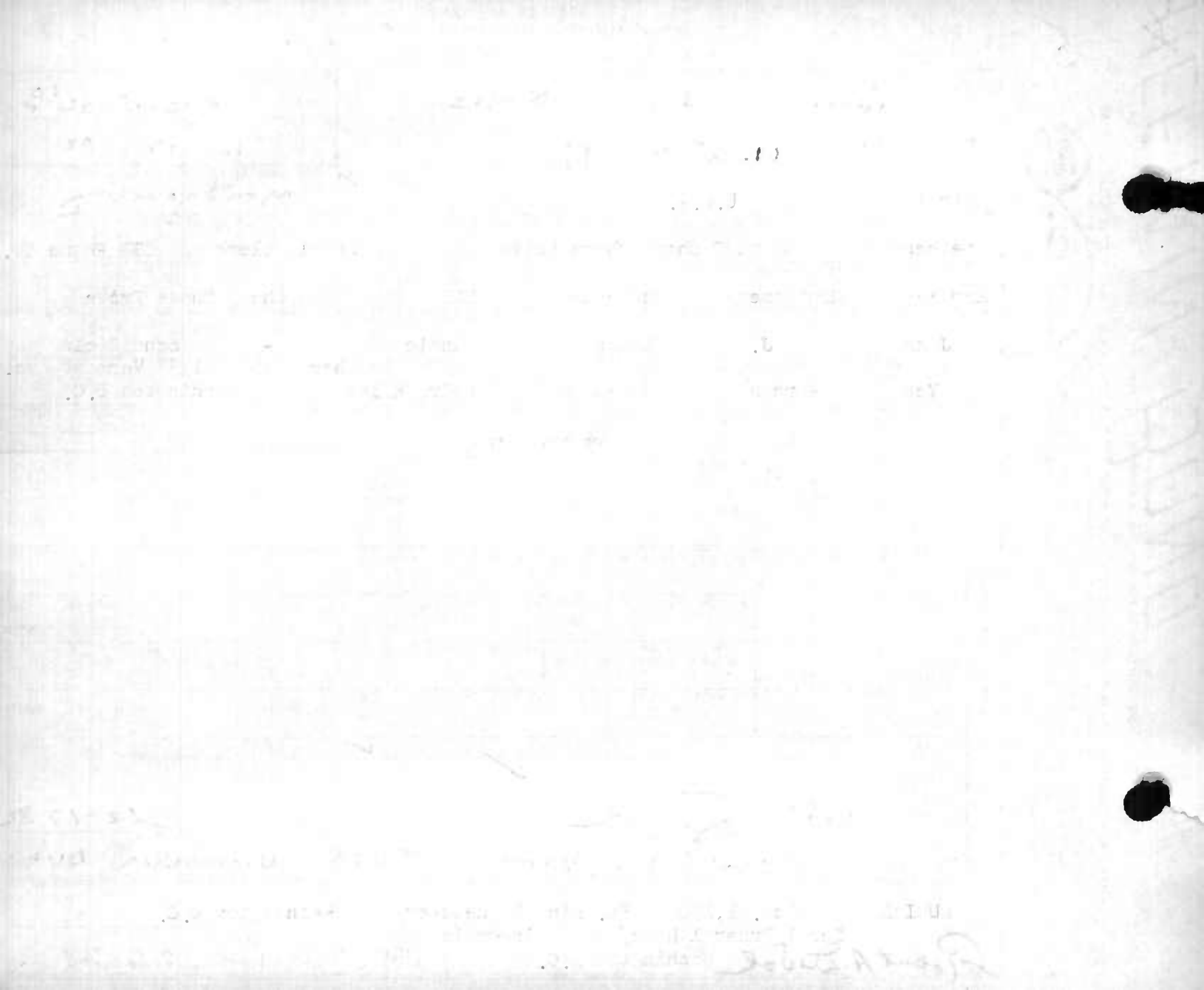
DEC 17 1985
George G. Smith

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM. 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 2 6 4 5	
FOR 1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) John D. Kolas.										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN. 12-15-82 9 M	
3. SEX M	4. RACE W	5. DATE OF BIRTH 12-28-33		6. AGE (IN YEARS) (LAST BIRTHDAY) 49 YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 12-17-82 9 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4830 Chevy Chase Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supply Clerk		12b. KIND OF BUSINESS OR INDUSTRY C&P Phone Co.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4830 Chevy Chase Drive			
14. FATHER'S NAME (FIRST MIDDLE LAST) John J. Kolas				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Annie Scholfield							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Korean		16b. SOCIAL SECURITY NO. 230 38 3632		17. INFORMANT Brother Spiro Kolas		ADDRESS 1337 Vermont Ave. Washington D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9530 IMMEDIATE CAUSE (a) Hanging Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . TITLE (SPECIFY) _____										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE John Pauber				M.D. _____ MEDICAL EXAMINER				DATE SIGNED 12-17-82			
EXAMINER'S NAME (TYPE OR PRINT) John Pauber				ADDRESS 8218 Wisconsin Ave.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Dec. 21, 1982		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.			
24. FUNERAL DIRECTOR NAME Robert A. DeSol ADDRESS Washington D.C.				25a. DATE REC'D. BY REGISTRAR DEC 27 1982				25b. REGISTRAR'S SIGNATURE John J. Canfield			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 5 4 6

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Steve W. Koustenis			2a. DATE OF DEATH MONTH DAY YEAR December 22, 1982			2b. HOUR 1 AM	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 22 19		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRODUCE COMPANY		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1702 WESTCHESTER DRIVE 20902							
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM G. KOUSTENIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHRISTIANA MARITSIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 977-18-8642		17. INFORMANT ADDRESS ANNA L. KOUSTENIS SAME AS 13 WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Oat cell lung cancer 1629 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) meningeal, bone, node metastases							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/21 1982, to 12/24 1982, that (1) (we) last saw the deceased alive on 12/24 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Peter B. Sherer				DEGREE MD		22c. DATE SIGNED 12/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER B. SHERER MD				22e. ADDRESS 3947 Ferrara Dr. Wheaton Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/24/82		23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.	
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR DEC 30 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

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Attention of the Librarian
The following books are
for the library of the
University of Chicago
and are to be placed
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Library of the University of Chicago
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CHICAGO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

29

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 6 4 7			
FOR 1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MURRAY KRAFT				2a. DATE OF DEATH MONTH DAY YEAR Dec. 25, 1982		2b. HOUR 12:10p	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 15, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5225 Pooks Hill Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stockbroker(Ret)		12b. KIND OF BUSINESS OR INDUSTRY Brokerage	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13e. STREET ADDRESS 5225 Pooks Hill Road	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Kraft		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Morovitz		ADDRESS Maryland 20851			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-10-6080		17. INFORMANT Lynn Pruitt; 303 Nimetz Ave:Rockville,			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4280 CONGESTIVE HEART FAILURE IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 3/14 , 19 78 , to 12/7 , 19 82 , that (I) (we) last saw the deceased alive on 12/25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Martin Kraft				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-25-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN KRAFT				22e. ADDRESS 13-15 E. DEER PARK DRIVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-28-82		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn.		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Va.	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 29 1982 John J. Conner			

BP

7



COMPASSIONATE HEART FAILURE

CHIEF

Went for
Marty



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 8232648						
1. DECEASED NAME (TYPE OR PRINT) FREDERICK W. KRIEGER			2a. DATE OF DEATH MONTH DAY YEAR 12-12-82			2b. HOUR 8:55 A M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 13 1907		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Routeman		12b. KIND OF BUSINESS OR INDUSTRY Dairy		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Krieger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dolly Spiedel			13e. STREET ADDRESS 4412 Edgefield Rd., zip 20895			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Ann A. Krieger see # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 5789 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypertension (c) Gastrointestinal Hemorrhage									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from June 1979 to Dec 12 1982 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 12-11 1982 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> did not view the body after death.									
22b. SIGNATURE John Tauber			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-12-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber			22e. ADDRESS Bethesda, Md. 8218 Wisconsin Ave.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 16, 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey					25a. DATE REC'D. BY REGISTRAR DEC 17 1982		25b. REGISTRAR'S SIGNATURE John J. Cichy		
P.A. Bethesda, Maryland									

DEC 17 1985
FBI - NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 3 2 6 4 9			
FOR 1. STATE REGISTRAR					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Francis</i> <i>JOSEPH</i> <i>LANIGAN</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>12-21-82</i>			2b. HOUR <i>4:52 PM</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>AUG 12, 1918</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NEW JERSEY</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.				
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>HOLY CROSS HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>ACCOUNTANT</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>DEPT OF NAVY</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <i>MARYLAND</i>	13b. COUNTY <i>MONTGOMERY</i>	13c. CITY OR TOWN <i>ROCKVILLE</i>	13e. STREET ADDRESS <i>11233 ASHLEY DRIVE 20852</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>JOSEPH LANIGAN</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>JANE HENNON</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES WW II</i>		16b. SOCIAL SECURITY NO. <i>133-05-7071</i>		17. INFORMANT ADDRESS <i>FRANCES M. LANIGAN SAME AS 13 WIFE</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>cardiogenic shock</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>acute myocardial infarction</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>12/19</i> 19 <i>82</i> to <i>12/21</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>12/21</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Joseph M. Solinas</i>				DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/22/82</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH M. SOLINAS</i>				22e. ADDRESS <i>SILVER SPRING, MARYLAND</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>12/24/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>SILVER SPRING MONT MD.</i>		
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 27 1982</i>				
500 UNIV. BLVD., WEST, SILVER SPRING, MD. 20901				REGISTRAR'S SIGNATURE <i>John J. Conner</i>				

MAILED
JAN 10 1964
U.S. AIR FORCE
OFFICE OF THE
ATTORNEY GENERAL



DEC 27 1963
U.S. AIR FORCE
OFFICE OF THE
ATTORNEY GENERAL
MONT. 10.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2		3		2		6		5		0			
1. DECEASED NAME (TYPE OR PRINT)												2a. DATE KNOWN OF DEATH			
David Allen Lannon												MONTH DAY YEAR 12 6 19 82			
3. SEX		4. RACE		5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD			
M		W		Feb 19 37		45 YRS.		MONTHS DAYS		HOURS MIN		12 2 26 19 82			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Ohio				USA								Montgomery MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Olney				Montgomery General Hospital								Staff Spec.			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Md				Mont				Gaithersburg				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME (FIRST MIDDLE LAST)				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
Donald Lannon				Belva Rittenhouse				Yes				287 32 8966			
17. INFORMANT				ADDRESS				Item 13							
Patricia A. Lannon															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Acute Myocardial D.I.S.</u>															
4291															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
None															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								DEC 6 1982			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				12/9/82		Arlington National				Ft. Meyer, Virginia					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Olin L. Molesworth, P.A., Damascus, Md.				DEC 10 1982				John J. [Signature]							

2

COLLIER

11/11/11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the county office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 6 5 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) DAISY M. Layton				2a. DATE OF DEATH MONTH DAY YEAR December 8, 1982				2b. HOUR 12 35 PM			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 28, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. STATE Md.				13b. CITY OR TOWN PRINCE GEORGES CAMP SPRINGS		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6305 Joyce Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Minder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY SLUSHER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 577-28-6131		17. INFORMANT DANIEL O. LAYTON (SON) SAME AS #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 4275 IMMEDIATE CAUSE (a) Cardiac arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hour	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF cardiac arrhythmia										CO days	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Cerebral Infarct, gastrointestinal hemorrhage, pulm embolus, Colon carcinoma											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6525 Belcrest Rd Hyattsville					
22a. I certify that (I) (this hospital) attended the deceased from 11/14 19 82 , to 12/8 19 82 , that (I) (we) last saw the deceased alive on 12/8 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Anne K. Cantor, M.D.				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/8			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. CANTOR				22e. ADDRESS 6525 Belcrest Rd Hyattsville							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE DEC 11, 1982		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.E.CO. MARYLAND			
24. FUNERAL DIRECTOR NAME ADDRESS CHAMBERS FUNERAL HOME RIVERDALE, MARYLAND				25a. DATE REC'D BY REGISTRAR DEC 13 1982				25b. REGISTRAR'S SIGNATURE [Signature]			

720 12/29/91

2112428

1991 12 29 12:29 PM 720 12/29/91 2112428

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WHEN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										3 2 6 5 2																			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Walsh Lear										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12-21-1982										2b. HOUR OF DEATH 11:40 PM									
3. SEX M		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 10-9-17		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 65		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 21 19 82 11 43 PM																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.																	
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician				12b. KIND OF BUSINESS OR INDUSTRY Reed Elect. Co.													
13a. STATE MD.										13b. CITY OR TOWN MONTGOMERY CHASE										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 5300 BALTIMORE AVE							
14. FATHER'S NAME FIRST MIDDLE LAST George Lear										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Long																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes										16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942 to 1953										17. INFORMANT ADDRESS Wife, Kathleen L. Lear Same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) CORONARY ARTERIOSCLEROSIS } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDISTINCT																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 11 P.M. 12 2 1982										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR FOUND ON FLOOR										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME										21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5300 BALTIMORE AVE CHASE MONT. MD.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE <i>Francis C. Mayle</i>										TITLE (SPECIFY) M.D. Dept MEDICAL EXAMINER										DATE SIGNED 12/22/82									
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C. MAYLE										ADDRESS 8200 WILSON AVE BETHESDA MD																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE Dec. 24, 1982										23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.									
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Maryland										24. FUNERAL DIRECTOR NAME ADDRESS DeVol Funeral Home Washington, D.C.										25a. DATE RECD. BY REGISTRAR DEC 27 1982									

100 West 100th Street, New York, N.Y. 10025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsie P. Leech					2a. DATE OF DEATH MONTH DAY YEAR 12-27-82					2b. HOUR 10:30 PM
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 5 1893		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD COUNTY NI					13c. CITY OR TOWN Wash. D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Leon Pohlmann					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Hauser					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 263 41 1205		17. INFORMANT ADDRESS Edgewater, Md/ 21037			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3109 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Organic brain Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Congestive heart failure										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (his hospital) attended the deceased from 10-18 , 19 82 , to 12-27 , 19 82 , that (I) (we) last saw the deceased alive on 12-27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.										
22b. SIGNATURE James H. Brodsky MD					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-28-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James H. Brodsky MD					22e. ADDRESS 4701 Willard Ave, Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-30-1982		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Pearson's F. h. Falls Church, Virginia 22046					DATE RECEIVED BY REGISTRAR JAN 3 1983					
					REGISTRAR'S SIGNATURE James H. Brodsky					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be filed with this certificate.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		12 22 82		3 30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Caucasian		Sept. 28, 1890		92 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Florida		United States				Montgomery County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		BROOKE GROVE NURSING HOME		Physician		Medicine			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14211 London Lane 20853	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
William P. Leffler		Mary J. Hammond		Yes		WWI		Son	
						578-50-9130		Harrison H. Leffler Jr. same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:	
4292 IMMEDIATE CAUSE (a)		CARDIAC ARREST		4292 IMMEDIATE CAUSE (a)		CARDIAC ARREST		4292 IMMEDIATE CAUSE (a)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b) CONSEQUENCE OF		DUE TO (b) CONSEQUENCE OF		DUE TO (b) CONSEQUENCE OF		DUE TO (b) CONSEQUENCE OF	
		BIVENTRICULAR HT. FAILURE		BIVENTRICULAR HT. FAILURE		BIVENTRICULAR HT. FAILURE		BIVENTRICULAR HT. FAILURE	
		DUE TO (c) CONSEQUENCE OF		DUE TO (c) CONSEQUENCE OF		DUE TO (c) CONSEQUENCE OF		DUE TO (c) CONSEQUENCE OF	
		ARTERIO-SCLEROTIC C.V.D.		ARTERIO-SCLEROTIC C.V.D.		ARTERIO-SCLEROTIC C.V.D.		ARTERIO-SCLEROTIC C.V.D.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
CHRONIC RENAL FAILURE: O.B.S.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		21d. INJURY OCCURRED			
		P.M. 19							
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
22a. I certify that (1) (this hospital) attended the deceased from 9-1-82 to 12-22-82 that I saw the deceased alive on 12-21-82, and that in my (my) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Donald R. Lewis MD		MD		12/22/82		DONALD R. LEWIS MD		OLNEY MD 20832	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY	
Cremation		Dec. 23, 1982		Metropolitan Crematory		Alexandria		Virginia	
24. FUNERAL DIRECTOR NAME		24. FUNERAL DIRECTOR ADDRESS		25a. DATE OF BURIAL		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey		Funeral Homes, P.A., Bethesda, Maryland		DEC 29 1982		John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

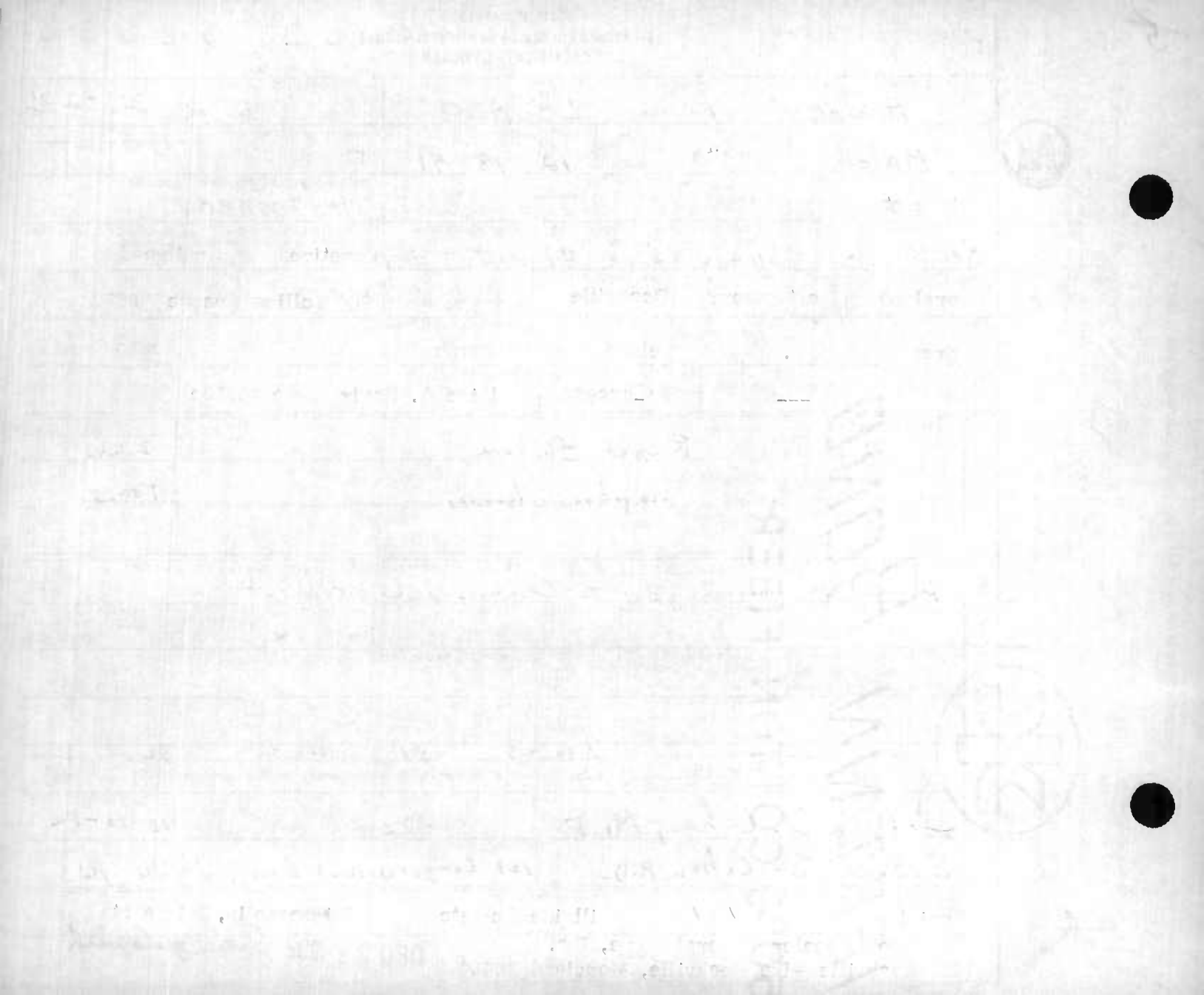
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 5 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Andrew P. LELAND				2a. DATE OF DEATH MONTH DAY YEAR 12 20 82 2b. HOUR 02 36 M			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 18 91		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH EACHITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Montgomery 13d. CITY OR TOWN Rockville				13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Andrew J. Leland				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Benson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. RR#A-788936		17. INFORMANT ADDRESS Elaine A. Davis same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure						2 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) nephrosclerosis						Years	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Aspiration pneumonia due to Cerebrovascular accident							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov 23 , 19 81 , to Dec 20 , 19 82 , that (I) last saw the deceased alive on Dec 19 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was not did not view the body after death.							
22b. SIGNATURE Sidney J. Cohen, M.D.				DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-20-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Cohen, M.D.				22e. ADDRESS 121 Congressional Lane, Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/82		23c. NAME OF CEMETERY OR CREMATORY Hillside Cemetery		23d. LOCATION Minneapolis, Minnesota STATE	
24. FUNERAL HOME OR NAME Pyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Maryland 20852				25. DATE RECEIVED BY REGISTRAR DEC 23 1982 SIGNATURE [Signature]			

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 6 5 6	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST										XX MONTH DAY YEAR	
2. SEX 3. RACE 4. DATE OF BIRTH 5. AGE (IN YEARS) 6. IF UNDER 1 YR. 7. IF UNDER 24 HRS.										2b. DATE KNOWN OF DEATH	
Male Oriental Feb. 14, 1898 84 YRS. MONTHS DAYS HOURS MIN										12-30-82 9:02AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED XX NEVER MARRIED WIDOWED DIVORCED										9. BALTIMORE CITY OR COUNTY OF DEATH	
China United States										Montgomery County	
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Bethesda Suburban Hospital										Journalist Journalism	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS											
Maryland Montgomery Bethesda YES X NO 6420 Hollins Drive											
14. FATHER'S NAME 15. MOTHER'S MAIDEN NAME											
Chiseng Lin Sonbeng Yang											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS											
No 577-84-4414 Jane Lin Fu, Daughter, Same as item #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Multiple injuries											
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?										YES X NO	
21a. EXTERNAL CAUSE WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
XOR 11:AM 12-28-82 pedestrian struck by an automobile											
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION											
X 11:AM street Old Georgetown Rd. & Lone Oak Montgomery Co., Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes Accident XX Suicide Homicide Undetermined manner											
ACTUAL SIGNATURE TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED											
Margarita A. Korell, M.D. Assistant 111 Penn Street 12-31-82											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION											
Burial Jan. 3, 1983 Washington National Cemetery Suitland, Maryland											
24. FUNERAL DIRECTOR NAME 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland 12-31-82											

BP

1. NAME (Last, first, middle initial)
2. GRADE
3. TITLE
4. ADDRESS
5. CITY
6. STATE
7. ZIP CODE
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9. FAX NUMBER
10. E-MAIL ADDRESS
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623. DATE
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 5 7

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HILDA ELIZABETH LITTLE			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 8 1982		2b. HOUR M 2:00p
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH JUNE 20 1897		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCOTLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL, NAVAL MEDICAL CMD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MARYLAND MONTGOMERY SILVER SPRING			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BANNERMAN FYFE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH ANDERSON SMART		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 579-12-7720		17. INFORMANT ADDRESS WILLIAM JOSEPH LITTLE 15930 WOODS CENTER RD SILVER SPRING, MD 20906	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): GI BLEED, ORGANIC BRAIN SYNDROME					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3 DECEMBER 19 82 to 8 DECEMBER 19 82 , that (I) (we) last saw the deceased alive on 8 DECEMBER 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE RK Ferguson LTMC, MD				22c. DATE SIGNED 9 DEC 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. K. FERGUSON, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/13/82		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.					
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 N.H. Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR DEC 13 1982	
				25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1500.

BP

NOTICE

MAILED



SEP 1 1924

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 5 8

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Will</u> MIDDLE: <u>H.</u> LAST: <u>Logan</u>			2a. DATE OF DEATH MONTH: <u>Dec</u> DAY: <u>3</u> YEAR: <u>1982</u>		2b. HOUR <u>7:35</u> PM
3. SEX <u>Male</u>	4. RACE <u>Negro</u>	5. DATE OF BIRTH MONTH: <u>Feb.</u> DAY: <u>26</u> YEAR: <u>1897</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>85</u> YRS	IF UNDER 1 YEAR MONTHS: _____ DAYS: _____	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N.C.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Rockville Montgomery Co.</u> MD		
10. CITY OR TOWN OF DEATH <u>Rockville</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Potomac Village Nursing Home</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired Minister Church</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <u>Md.</u>	13b. COUNTY <u>Montgomery S. Spring</u>	13c. CITY OR TOWN <u>Rockville</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>13309 Bea-Kay Drive</u>	
14. FATHER'S NAME FIRST: <u>William</u> MIDDLE: _____ LAST: <u>Logan</u>		15. MOTHER'S MAIDEN NAME FIRST: <u>Unknown</u> MIDDLE: _____ LAST: _____			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>WW1</u>		17. INFORMANT <u>Arluss Wiggins Same as 13e.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> <u>2041</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic lymphocytic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>5 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____	
22a. I certify that (1) (this hospital) attended the deceased from <u>Dec 3</u> , 19 <u>82</u> , to <u>Dec 3</u> , 19 <u>82</u> , that (we) lost saw the deceased alive on <u>never</u> 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Mark S. Rosen</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>12/4/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Mark S. Rosen, MD</u>		22e. ADDRESS <u>Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>Dec. 9, 1982</u>	23c. NAME OF CEMETERY OR CREMATORY <u>YOUNGS CHAPEL CEM.</u>		23d. LOCATION CITY OR TOWN: <u>MOORESBORO, NC.</u> COUNTY: _____ STATE: _____	
24. FUNERAL DIRECTOR NAME <u>MASON INC.</u>		ADDRESS <u>1061 GOOD HOPE RD SE.</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 9 1982</u>	
		REGISTRAR'S SIGNATURE <u>John J. Carver</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

14

20% COTTON
1/16 IN

Washco Inc. 1000 GARDEN ST. SE
DET. 48000

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Marguerite MCP. Lowe MARGUERITE MCP. LOWE					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 12 19 82 150 P.M.				
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR July 29 1885		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CTY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHEVY CHASE RET. + NRG CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Interior Decorator		12b. KIND OF BUSINESS OR INDUSTRY Home Furnish.	
13a. STATE Md. 20215		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 113 Primrose St.	
14. FATHER'S NAME FIRST MIDDLE LAST Dorsey Mahon McPherson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Deland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-12-3693-D		17. INFORMANT ADDRESS Charles F. Pentz 1409 N. Buchanan St. Arl. VA 22205					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-12 , 19 82 , to 12-19 , 19 82 , that (I) (we) last saw the deceased alive on 12-19 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE James X Brodsky MD				DEGREE Covering for Dr. L. Hall ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-19-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Brodsky MD				22e. ADDRESS 4701 Willard Ave., Chevy Chase					
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE Dec. 21, '82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md.			
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Inc. 5130 Wisc. Av. NW Washington, DC 20016				25a. DATE REC'D. BY REGISTRAR DEC 27 1982 REGISTRAR'S SIGNATURE John J. Carver					

2130 Wisc. v. W. Washington, 20 2016

2016 Wisc. v. W. Washington, 20 2016

Creation Dec. 21, '88 Cedar Hill Cemetery

England

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no

200-12-2697-D Charles F. Rente

1409 N. Michigan St.

Dorsey

London

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 6 6 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME FIRST MIDDLE LAST SAM LUBAR				2a. DATE OF DEATH MONTH DAY YEAR 12 14 82		2b. HOUR 10 50 PM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 1 11 98		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7 UNDER 1 YEAR # UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE 1471			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant		12b. KIND OF BUSINESS OR INDUSTRY Grocer	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11215 Oakleaf Drive, #117	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Lubar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Chaya Sachs					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-40-1882		17 INFORMANT Clara Lubar (Wife)		ADDRESS Same as No. 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 8415		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-14-82 to 12-14-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Robert Kramer				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRAMER				22e. ADDRESS 8630 FERTON ST. S.E. 816 SPOND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/16/1982		23c. NAME OF CEMETERY OR CREMATORY Dist. of Col. Lodge		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.	
24 FUNERAL DIRECTOR NAME Donald M. Stein Hebrew Memorial F. H.				25a. DATE REC'D. BY REGISTRAR DEC 20 1982		25b. REGISTRAR'S SIGNATURE Sam J. Connel	
26 FUNERAL HOME NAME 232 Carroll Street, N. W. Washington, D. C.							



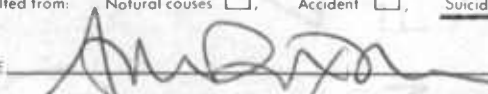
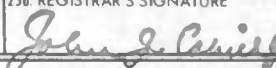
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Catharine		MIDDLE L.		LAST LUDEWIG		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 14 1982		2b. HOUR M 12:30	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 22, 1950	6. AGE (IN YEARS) BIRTHDAY YRS. 32	IF UNDER 1 YR. MONTHS DAYS HOURS MIN 32	IF UNDER 24 HRS. HOURS MIN 32		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 16 1982		2d. HOUR M 12:30		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dist. of Col.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) woods behind 7520 Sebago Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7520 Sebago Road			
14. FATHER'S NAME FIRST MIDDLE LAST Charles K Ludewig		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catharine Delaney		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-60-4286		17. INFORMANT ADDRESS Catharine D. Ludewig item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head (handgun) 9550 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12-14- 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) Self-inflicted.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) woods behind		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7520 Sebago Rd., Bethesda, Montgomery, Md.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 		M.D. Assistant		MEDICAL EXAMINER				DATE SIGNED 12-17-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 20, '82		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington VA.			
24. FUNERAL DIRECTOR NAME Jos. Gawler's Sons, Inc. 5130 Wisc. Av NW Washington, DC 20016						25a. DATE REC'D. BY REGISTRAR DEC 21 1982		25b. REGISTRAR'S SIGNATURE 			

Female White June 22, 1930 35

Mat. of Col. U S A.

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Bedstead

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No

Printed Dec. 20, 1935 Washington National Cam. Va.

John Lawler's Sons, Inc. 2170 1st St. N.W. Washington, D.C. 20036



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Williams J. LUEHRS, Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>December 4, 1982</i>		2b. HOUR <i>12:50 P.M.</i>		
3. SEX <i>MALE</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 13, 1920</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United State</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY County, MD.</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Owner Amoco Gas Station</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Potomac</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <i>(20854) 12916 Brushwood Terrace</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>William J. Luehrs, Sr.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emily Dunn</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>216 12 4508</i>		17. INFORMANT <i>wife</i>		ADDRESS <i>Julia A. Luehrs Same as item 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>1629 IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ()							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>May 1982</i> to <i>December 4, 1982</i> , that (I) (we) lost saw the deceased alive on <i>12/4</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard H. Poulson</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/4/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard H. Poulson</i>		22e. ADDRESS <i>10400 WOLF AVE CORRECTION AVE KENSINGTON MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 6, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 6 - 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

MEDICAL CERTIFICATION



Handwritten text, mostly illegible due to fading and bleed-through. Some words like "Society" and "of" are faintly visible.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VR A 15(4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) RUTH MAUREEN LUXTON					2a. DATE OF DEATH MONTH DAY YEAR Dec. 21 1982				
3. SEX Female					4. RACE White				
5. DATE OF BIRTH MONTH DAY YEAR May 22 1924					6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England					7b. CITIZEN OF WHAT COUNTRY? Great Britian				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Takoma Park					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assoc. Director Religion					12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland					13b. COUNTY Mont.				
13c. CITY OR TOWN Silver Spr.					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS 12516 Waldo Lane									
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Wynne					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Garstang				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no					16b. SOCIAL SECURITY NO.				
17. INFORMANT Jack W. Luxton, Ridgewood, New Jersey					ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: GLIOBLASTOMA IMMEDIATE CAUSE (a) 1919 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several Wks.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the deceased) attended the deceased from Dec 15 1982 , to Dec. 21 1982 , that (I) (we) saw the deceased alive on Dec. 21 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David Cromwell M.D.					22c. DATE SIGNED 12/22/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID CROMWELL, M.D.					22e. ADDRESS 831 Univ. Blvd. E., Sil. Sp. Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Transit-Burial					23b. DATE Dec. 30 1982				
23c. NAME OF CEMETERY OR CREMATORY North Watford Cem.					23d. LOCATION CITY OR TOWN COUNTY STATE North Watford, England				
24. FUNERAL DIRECTOR NAME TAKOMA FUNERAL HOME, 254 Carroll St. N.W.D.C.					25a. DATE REC'D. BY REGISTRAR DEC 23 1982				
25b. REGISTRAR'S SIGNATURE John J. Canfield									

TAKOMA TOWER, 250 Carroll St. N.W.D.C.

Transit-Bureau, Dec. 1982 North Western Cem. North Western, England

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 3 2 6 6 4 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Seymour Lynn</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>12/10/82</i>			2b. HOUR <i>6:50A</i> M	
3. SEX <i>male</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>JULY 12, 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NEW YORK</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Postal Carrier</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. POSTAL</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13e. STREET ADDRESS <i>11300 Cloverhill Dr. (20902)</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>MORRIS LYNN</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>REBECCA FASS</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>YES WW II</i>					16b. SOCIAL SECURITY NO. <i>082-14-8673</i>		17. INFORMANT ADDRESS <i>Edna Lynn; 11300 Cloverhill Dr.; Silver Spring, Maryland 20902</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>shock</i> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Lung Cancer</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immed 2 years</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>12/15/80</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>19</i>			21f. LOCATION CITY OR TOWN COUNTY STATE <i>19</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/15/80</i> to <i>12/10/82</i> , that (I) (we) last saw the deceased alive on <i>12/10/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Arnon Primack MD</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <i>12/10/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ARON PRIMACK, MD</i>						22e. ADDRESS <i>106 Irving Street, N.W., #421; Wash., D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12/12/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Montifiore</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Pine Lawn; L.I.; New York</i>		
24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPEL</i>						25a. DATE REC'D. BY REGISTRAR <i>DEC 16 1982</i>			
24. FUNERAL DIRECTOR ADDRESS <i>1170 Rockville Pike; Rockville, Md. 20852</i>						25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8 2 3 2 6 6 5 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE ANN LAST MALCOMSON					2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 28, 1982			2b. HOUR 12:30 P.M.		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH JAN ²⁶ 1916		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2705 ARVIN STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASST. MANAGER		12b. KIND OF BUSINESS OR INDUSTRY BARRICINI		
13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST ERNEST MIDDLE PRANGLEY LAST					15. MOTHER'S MAIDEN NAME FIRST ANNIE MIDDLE STOUTENBURGH LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-36-2975		17. INFORMANT ADDRESS GEORGE D. MALCOMSON SAME AS 13 HUSBAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Metastases</u> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Sarcoma of Uterus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>14 mos.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>82</u> , to <u>Dec 28</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Dec 13</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>G. Lennard Gold</u> M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/28/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. LENNARD GOLD					22e. ADDRESS 8630 FENTON STREET, SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/30/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					25a. DATE REC'D. BY REGISTRAR JAN 6 1983 REGISTRAR'S SIGNATURE <u>John J. [Signature]</u>					

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IN THE YEAR 1803

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE PLACED IN YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 6 6 6	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Corinne R. Malmgren						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12/4 19 82		2b. HOUR			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 27, 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 77		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12/5 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FINLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8414 Flower Avenue, #1				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8414 Flower Avenue, #1			
14. FATHER'S NAME FIRST MIDDLE LAST JAAKOB TANNER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HILMA SAHL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS GEORGE J. ERBECK, 729 S. ALFRED ST. ALEX. VA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 12/6/82			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/7/82		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.D. Md.			
24. FUNERAL DIRECTOR Takoma Funeral Home, 254 Carroll Rd. DC						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 9 1982 John J. Carver					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 6 6 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) John Richard Manna				2a. DATE OF DEATH MONTH DAY YEAR 12 5 82		2b. HOUR 7:59 A.M.	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 26 17		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONN.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY ----	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND 13c. CITY OR TOWN CAROLINE RIDGELY				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 208 FIRST ST.	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN MANNA				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 044-03-6625		17. INFORMANT ADDRESS 208 FIRST ST. RIDGELY, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CORONARY ART. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)				21660 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ---							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 29, 1982 to Dec 5, 1982 , that I (we) last saw the deceased alive on Dec 4, 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE James Ronan		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-5-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES RONAN				22e. ADDRESS 7600 CARROLL AVE TAKOMA PARK, MD.			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE DEC. 8, 1982		23c. NAME OF CEMETERY OR CREMATORY RIDGELY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE RIDGELY CAROLINE MD.	
24. FUNERAL DIRECTOR NAME James E. Lerner ADDRESS 1001 E. ...				DATE REC'D BY REGISTRAR DEC 14 1982 REGISTRAR'S SIGNATURE John J. Connel			

BP

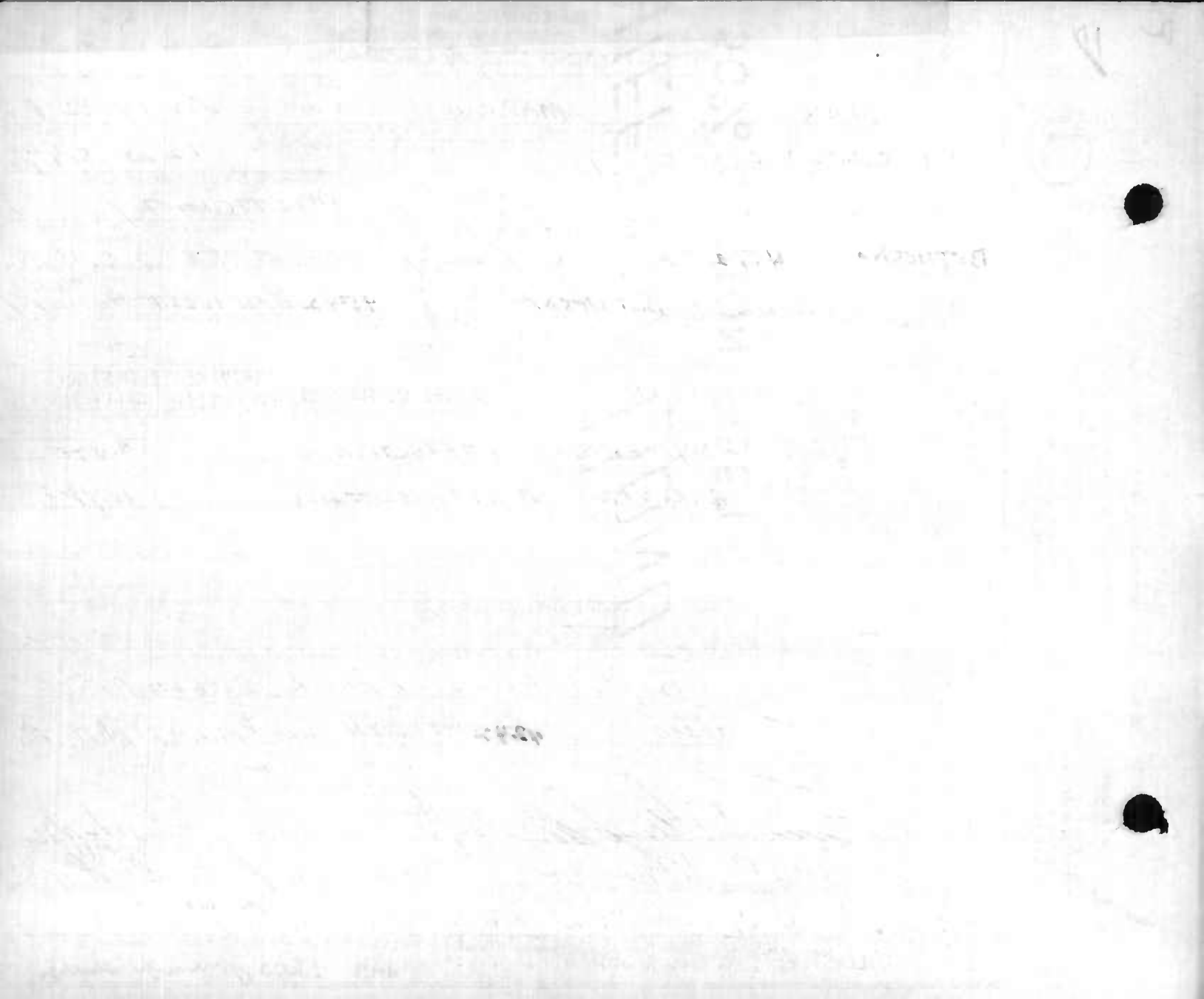
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. 3 2 0 6 8	
1. DECEASED NAME (TYPE OR PRINT) MAX		2. DATE KNOWN OF DEATH ESTIMATED 12 23 19 82	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 5 DAY 21 YEAR 09	6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.
10. CITY OR TOWN OF DEATH CHEVY CHASE	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) APARTMENT 820 4242 EAST WEST HIGHWAY	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT CLERK	12b. KIND OF BUSINESS OR INDUSTRY U. S. GOV'T.
13a. STATE MD	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN CHEVY CHASE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST ISAAC MIDDLE MARCUS LAST MARCUS	15. MOTHER'S MAIDEN NAME FIRST JENNIE MIDDLE WEINER LAST WEINER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. N/A	17. INFORMANT SAMUEL C. MARCUS, 13417 KEATING STREET, ROCKVILLE, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) CHRONIC ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 10 YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12 23 1982	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) FOUND ON FLOOR LOCKED APT.	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME	21f. LOCATION STREET 4242 EAST WEST HIGHWAY CITY OR TOWN BETHESDA COUNTY MONTGOMERY STATE MD	
22. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE Francis C. Nix	TITLE (SPECIFY) M.D.	DATE SIGNED 12/27/82	
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C NIX	ADDRESS 5200 Wisconsin Ave Bethesda MD		
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 1/4/1983	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY	23d. LOCATION CITY OR TOWN BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR JAN 7 1983	25b. REGISTRAR'S SIGNATURE James J. Connelley



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 6 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Irving T. A. Markentor			2a. DATE OF DEATH MONTH 12 YEAR 1982 DAY 12 HOUR 12 ^{PM}		
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH 12 DAY 13 YEAR 28	6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PUERTO RICO	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> SEPARATED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTEGOMERY MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NAVAL ARCHITECT		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY MONTEGOMERY	13c. CITY OR TOWN TAKOMA PARK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 7600 MAPLE AVENUE	
14. FATHER'S NAME FIRST ANTONIO MIDDLE TORRES LAST TORRES		15. MOTHER'S MAIDEN NAME FIRST ADELA MIDDLE ALBINO LAST ALBINO			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 054-30-7482		17. INFORMANT ADDRESS LUIS A. IRIZARRY - 7600 MAPLE AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4912 IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Asthmatic Bronchitis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Osteoporosis; Pneumothorax; Hemangioma of Liver					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/14 , 19 82 , to 12/19 , 19 82 , that (I) (we) lost saw the deceased alive on 12/15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alfred Munzer		DEGREE M.D.		22c. DATE SIGNED 12/20/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alfred Munzer M.D.		22e. ADDRESS 7600 Carroll Avenue Takoma Park Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 23, 1982		23c. NAME OF CEMETERY OR CREMATORY Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE YAU CO. PUERTO RICO					
24. FUNERAL DIRECTOR NAME Walter Walters ADDRESS 254 Carroll St. N.W. Wash. D.C. 20012		25. DATE REC'D. BY REGISTRAR DEC 22 1982			
26. REGISTRAR'S SIGNATURE John J. Carver					



11/11/11

20% COTTON



Printed by the Government of India
New Delhi

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ALBERT

Alan

MARSHALL

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 12-12-82
2b. HOUR 19

3 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YR.

IF UNDER 24 HRS.

Male

Caucasian

Nov. 13, 1948

34 YRS.

2c. DATE PRONOUNCED DEAD 12-12-82
2d. HOUR 5:45P

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Takoma Park, Md.

USA

Montgomery County

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

Rockville

Shady Grove Hospital

Computer Specialist

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

Maryland

Montgomery

Clarksburg,

YES ☐ NO ☒

10402 Regina Court

14. FATHER'S NAME

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

MIDDLE

LAST

Charles

Marshall

Jewel

Margerum

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

214-46-6251

17. INFORMANT

ADDRESS

Mrs. Mary Beth Marshall Clarksburg, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

4292

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 12-13-82

EXAMINER'S NAME (TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

COUNTY

STATE

Burial

12/15/82

Hyattstown Chris. Ch. Cem Hyattstown, Montgomery, Md.

Funeral Director
Robert E. Bailey & Son

ADDRESS 1201 N. Market St.
Frederick, Md. 21701

25a. DATE REC'D. BY REGISTRAR

REGISTRAR'S SIGNATURE

DEC 16 1982

John J. Connel

Funeral Homes, P.A.

RECEIVED - 1947

RECEIVED - 1947

RECEIVED - 1947

RECEIVED - 1947



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page*4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

BP _____

DHMH - 16 50M.1/BI
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	3	2	6	7	1
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Martin Edward J. Martin										2a. DATE OF DEATH MONTH DAY YEAR 12/6/82				2b. HOUR 8³⁰ P M		
3. SEX Male			4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Oct. 1, 1895			6. AGE (IN YEARS (LAST BIRTHDAY)) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.								
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Montg		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 18 MOORE DRIVE							
14. FATHER'S NAME FIRST MIDDLE LAST Clem Martin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Johnson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 577-16-6878		17. INFORMANT ADDRESS Richard Martin (son) 1001 Rockville Pike Rockville Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post code - cardiac arrest 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DOE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic heart disease DOE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Essential hypertension																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 19 70 to 12-6 19 82 , that (I) (we) last saw the deceased alive on 12-6-82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Donald L Bury					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-6-82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald L Bury					22e. ADDRESS 809 Veirs Mill Rd Rockville											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-11-82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg. Md.								
24. FUNERAL DIRECTOR NAME George R. Snowden					24b. ADDRESS 246 N. Wash. St. Rockville, Md.			25a. DATE REC'D. BY REGISTRAR DEC 13 1982		25b. REGISTRAR'S SIGNATURE John J. Connel						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of this.

Item #13e per phone call w/Fun. Home

FOR 1- STATE 1/5/83 rc REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MERVIN MIDDLE C LAST MARTIN		2a. DATE OF DEATH MONTH DAY YEAR 12 21 82		2b. HOUR 3:27 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 25 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp, Bethesda		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trans. Specialist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Md. 20657 Anne Arundel		13b. CITY OR TOWN Lusby		13c. STREET ADDRESS Box 26 Gunsmoke Trail	
14. FATHER'S NAME FIRST MIDDLE LAST Roy Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Huffman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-20-9555		17. INFORMANT ADDRESS A. Carolyn Martin. Same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Inter-capillary Glomerulosclerosis, Diabetes Mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one day years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7:05 19 57, to Dec 21 19 82, that (I) (we) lost saw the deceased alive on Dec 21 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE DeWitt E. DeLawter MD				22c. DATE SIGNED Dec 21, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DeWitt E. DeLawter				22e. ADDRESS 6318 Democracy Blvd Bethesda Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/1982		23c. NAME OF CEMETERY OR CREMATORY Washington National Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland		24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.			
25a. DATE REC'D. BY REGISTRAR DEC 27 1982				25b. REGISTRAR'S SIGNATURE John J. Carver	

BP

2130 West Ave., N.E., Wash., D.C.
Joseph Lawrence's Sons Inc.
1251 1/2 13th St. S.W. Washington National Com. Building
Burial

No. 20657 Anne Marie Murphy
WFO-20-9552 A. Carolyn Martin. Same as item 13

Boy Martin Mary William

Box 26 Dunsmuir Trail

Trane. Specialist U.S. Army.

U.S.A.

xx

Jan. 22 1915

07

MARTIN

MURPHY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN MARZO		2a. DATE OF DEATH MONTH DAY YEAR 12-11-82		2b. HOUR MIN. 653	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 22, 1914	
6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. USA		7b. CITIZEN OF WHAT COUNTRY? USA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Music Teacher	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN SSpring	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Dick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Zarin		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 578-44-8675		17. INFORMANT ADDRESS Frank Marzo; 1901 Arcola Ave., SSpg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma 2028 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/11/82 to 12/10/82 , that (I) (we) last saw the deceased alive on 12/10/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. S. Garcia		DEGREE M.D.		22c. DATE SIGNED 12/11/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVIN		22e. ADDRESS 8630 FENTON ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-13-82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Washington, D.C.	
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Md.		23e. DATE REC'D. BY REGISTRAR DEC 16 1982		23f. REGISTRAR'S SIGNATURE John J. Carver	
24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg Chapels; 1170 Rockville Pike					

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 2 3 2 6 7 4 CERTIFICATE OF DEATH				
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH MONTH DAY YEAR				
FIRST MIDDLE LAST Arthur Walton Matthews					December 8, 1982				
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
Male		Caucasian		MONTH DAY YEAR Dec. 29, 1902		79 YRS.		10:50 am	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		United States				Montgomery County MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Potomac Valley Nursing Home				Carpenter		Self-Employed	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Arthur Walton Matthews					Grace McGaha				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					214-03-6281-A		6023 Needwood Road Mildred Kephart Rockville, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 15 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebrovascular accident									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the deceased) attended the deceased from 19 65, to 12-8, 19 82, that (I) last saw the deceased alive on 12-3, 19 82, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (the deceased) (did not) view the body after death.									
22b. SIGNATURE W. G. Hall					22c. DEGREE M.D.			22d. DATE SIGNED 12/8/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) William G. Hall, M.D.					22f. ADDRESS 615 West Montgomery Avenue Rockville, Maryland 20850				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Dec. 11, 1982		Parklawn Memorial Park		Rockville, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
					DEC 13 1982		John A. Smith		

MEDICAL CERTIFICATION

10:00 AM

11:00 AM

12:00 PM

1:00 PM

2:00 PM

3:00 PM

4:00 PM



Corporate Development
H. J. ...

... ..

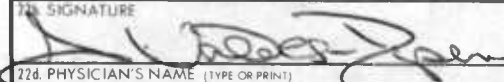
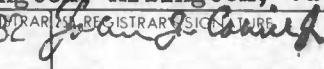


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 6 7 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MATTHEW MICHAEL MAXWELL				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 2 1982		2b. HOUR a m 6:36 a	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 2 1982		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN 46	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE OHIO		13b. COUNTY SUMMIT		13c. CITY OR TOWN STOW		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD LABELLE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TERRA LYNN MAXWELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS TERRA LYNN MAXWELL, 1503 HIBBARD DRIVE,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7599 IMMEDIATE CAUSE (a) CONGENITAL ANOMALIES DUE TO, OR AS A CONSEQUENCE OF (b) PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 2, 1982 , to DECEMBER 2, 1982 , that (I) (we) lost saw the deceased alive on DECEMBER 2, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3 DEC 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. VALDES-DAPENA, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-8-1982		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington, Va	
24. FUNERAL DIRECTOR NAME W.W. Chambers Co 8655 Georgia Ave, Sil. Spg. Md.				25. DATE REC'D. BY REGISTRAR DEC 10 1982 			



[Handwritten signature]

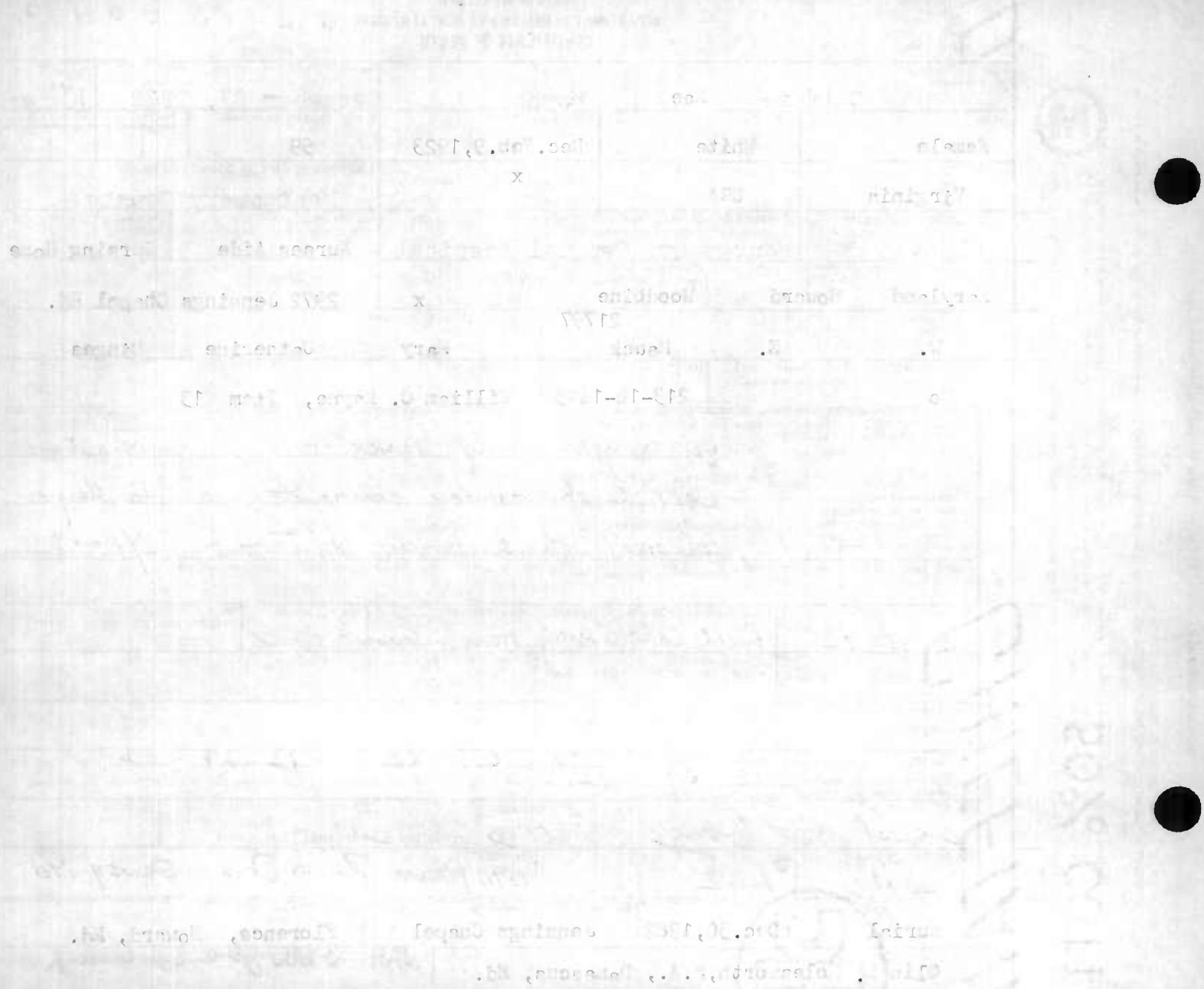
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 6 7 6			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
Cliffie Mae Mayne				December 27, 1982			
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Feb. 9, 1923		59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		USA				Montgomery County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Olney		Montgomery General Hospital				Nurses Aide	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS					
Nursing Home		2972 Jennings Chapel Rd.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Howard		Woodbine		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
W. E. Mauck		Mary Catherine Dinges		(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
No		16b. SOCIAL SECURITY NO.		17. INFORMANT			
		213-16-1425		William C. Mayne, Item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left Cerebrovascular accident.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced atherosclerotic obliterans</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 minutes</u> <u>12 days</u> <u>years.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
<u>12-15-82</u>		<u>Right Carotid Artery Stenosis Surgery</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-6-82</u> to <u>12-27-82</u> , that (I) (we) lost saw the deceased alive on <u>12-27-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Sol Phay</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Sol PHAY</u>				22e. ADDRESS <u>18111 Prince Philip Drive, Olney Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Dec. 30, 1982		Jennings Chapel		Florence, Howard Md.	
24. FUNERAL DIRECTOR NAME				25. REGISTRY			
Olin L. Molesworth, P.A., Danascus, Md.				JAN 3 1983			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 7:45 AM											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		21. MONTH DAY YEAR		22. HOUR	
Macon		R.		McArtor				Dec. 11, 1982				7:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD	
Female		White		Nov. 8, 1893		89 YRS.						Dec. 11, 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		USA				Montgomery County						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		1805 Forest Glen Road		Organist		Church							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20910					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		1805 Forest Glen Rd. S. S., MD			
John		Lynette (NMN)		NO		579-44-1039		Mrs. Lynette R. Burke		20910			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20. AUTOPSY?									
PART 1 DEATH WAS CAUSED BY:		NONE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
IMMEDIATE CAUSE (a)		Acute Myocardial Disease											
DUE TO, OR AS A CONSEQUENCE OF		Chronic Myocardial Disease											
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		NONE											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
Dr. John S. Rogers, M. D.		Deputy		Dec. 11, 1982									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		1919 Seminary Rd. Sil.Spr., MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		12/14/82		United Meth. Ch. Cem. Washington Street		Alexandria, Va.							
24. FUNERAL DIRECTOR		ADDRESS		P.O. Box 7428		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc.		Sil. Spr., Md.		DEC 15 1982				John J. Caniff					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 3 2 6 7 8			
1. FOR STATE REGISTRAR							
1. DECEASED NAME FIRST MIDDLE LAST GERTRUD NMN McCLUNG				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 23, 1982			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 12 1918		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) west GERMANY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL BETHESDA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPR.	
14. FATHER'S NAME FIRST MIDDLE LAST KARL THEODORE ULMER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA MARIA LEUKART			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-50-3531		17. INFORMANT ADDRESS WILLIAM ROBERT McCLUNG 12631 GEORGIA AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OVARIAN CARCINOMA 1830 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. NONE							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 18 DECEMBER 19 82, to 23 DECEMBER 19 82, that (I) (we) lost saw the deceased alive on 23 DECEMBER 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J.E. JENKS				DEGREE LCDR MC		22c. DATE SIGNED 12-24-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.E. JENKS				22e. ADDRESS Bethesda Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/82		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				P.O. Box 7428 Sil. Spr., Md.		25a. DATE REC'D. BY REGISTRAR 3 1983	
				25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8232679							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Elizabeth R. Mc Connell				2a. DATE OF DEATH MONTH DAY YEAR 12 5 82		2b. HOUR 5 ³⁵ P ^M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 5 1901		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nsg Home				12a. USUAL OCCUPATION (TYPE AND WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 420 Warrenton Drive	
14. FATHER'S NAME FIRST MIDDLE LAST William W. Raley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Mattingly							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE AND OR UNKNOWN) None		16b. SOCIAL SECURITY NO. 577 09 7726A		17. INFORMANT ADDRESS 15205 Peach Orchard Rd. S.S. A Diana J. Seibel (Daughter) Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 CARDIAC Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Anteroseptal Cardiovascular Disease 1042. DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Vascular Accidents 142. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Congestive Heart Failure, Epileptic Seizures									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 1-1-82, 19, to 12-5-82, 19, that (I) (we) last saw the deceased alive on 12-5-82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE George B. Patrick Jr M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-5-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE B. PATRICK JR M.D.				22e. ADDRESS 9221 Cokesville, Silver Spring, Md 20910					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/8/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (IF IN TOWN) S.S.		23e. COUNTY Mont. Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 N.H.Ave. S.S.Md.				25a. DATE REC'D. BY REGISTRAR DEC 7 - 1982		25b. REGISTRAR'S SIGNATURE Joan J. Connel			

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DEC 7 - 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 8 0

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Jennie		2. DATE OF DEATH MONTH 12 DAY 27 YEAR 82	
3. SEX Female		4. RACE Black	
5. DATE OF BIRTH MONTH Nov. DAY 16 YEAR 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Md.		13b. COUNTY Montgomery	
13c. CITY OR TOWN Silver Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1058 Good Hope Dr.		14. FATHER'S NAME FIRST (Unknown) MIDDLE (Unknown) LAST (Unknown)	
15. MOTHER'S MAIDEN NAME FIRST Lena MIDDLE Scott LAST College Pk.,		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)	
17. INFORMANT George Lee-8117 51st Ave., Md.		18. SOCIAL SECURITY NO. Unknown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. LOCATION CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Thomas E. Dooley M.D.		22c. DATE SIGNED 12/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Dooley M.D.		22e. ADDRESS 2901 Olney-Sandy Spring Rd. Olney Md. 20832	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/30/82	
23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Highland Park, Md.	
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON + SONS ADDRESS 4925 BURNBOUGH AVE. N.E.		25a. DATE REC'D. BY REGISTRAR DEC 29 1982	
25b. REGISTRAR'S SIGNATURE John J. Smith			

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Items #10a-22a Film G575 1/12/83 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GARY James MCGROGAN			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-3-82			2b. HOUR PM			
3. SEX Male	4. RACE Cauca.	5. DATE OF BIRTH MONTH DAY YEAR April 1, 1956	6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 12-3-82	7d. HOUR 11:58			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Snider Bro		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 14 Mills Road			13f. CITY OR TOWN 20877						
14. FATHER'S NAME FIRST MIDDLE LAST Joseph W. McGrogan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shirley M. Schwartz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 219-64-4804		17. INFORMANT Father ADDRESS 14 Mills Road Joseph W. McGrogan Gaithersburg, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stabwound of the chest 9560 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR 9:30 P.M. MONTH DAY YEAR 12/3/ 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted wound				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 511 S. Frederick Ave. Gaithersburg Montg. Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE H.R. Guard			TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12-4-82		
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn Street Baltimore, Md.						
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE Dec. 7, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland		
24. FUNERAL DIRECTOR NAME ROBERT A. BUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND					25. DATE REC'D. BY REGISTRAR DEC 8 - 1982 REGISTRAR'S SIGNATURE John J. Carver				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



DEC 8 1943

DEC 8 - 1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 2 3 2 6 8 2 REG. NO.				
I. DECEASED NAME (TYPE OR PRINT) Anne T. Mc Kenney					2a. DATE OF DEATH MONTH DAY YEAR Dec. 23, 1982			2b. HOUR 8³⁵ A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 21, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co., MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.- Secretary		12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. STATE D.C. 20016		13b. COUNTY Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS PO Box 39135			
14. FATHER'S NAME FIRST MIDDLE LAST Charles D. Taliaferro					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella M. Decatur				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-07-1843		17. INFORMANT James M. Taliaferro, Annandale, Virginia 22003					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5789 IMMEDIATE CAUSE (a) Acute Cardiac Arrest									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Upper Gastrointestinal Hemorrhage.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Right Pulmonary Infiltrate - Senile Dementia									
19a. DATE OF OPERATION June 1980			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Senile Dementia			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ---			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 1980 , 19 82 , to Dec 23 , 19 82 , that (I) (we) last saw the deceased alive on 12-22 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE P.P. Andrews MD					DEGREE MD			22c. DATE SIGNED 12-23-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P.P. ANDREWS					22e. ADDRESS 4977 BATTERVA BETHESDA MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/27/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016					25a. DATE REC'D. BY REGISTRAR DEC 29 1982		25b. REGISTRAR'S SIGNATURE John J. Connel		

2130 Wisconsin Ave., N.W., Washington, D.C. 20005
 Joseph Lawler's Sons, Inc.
 12/22/82 Ft. Lincoln Cemetery, Greenwood, Maryland

DEC 22 1982

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "James M. Talarico" and "Washington" are faintly visible.]

No	---	278-CV-1543	James M. Talarico, Manager, Virginia Beach	U.S. District Court, District of Columbia	Washington	X	W. Box 30132	Rec. - Secretary Noel L. Latta
Charles	U.S.	Talarico	U.S.	Washington	X	W. Box 30132	Rec. - Secretary Noel L. Latta	
Female	White	May 21, 1982	USA	X	Rec. - Secretary Noel L. Latta			

12/22/82

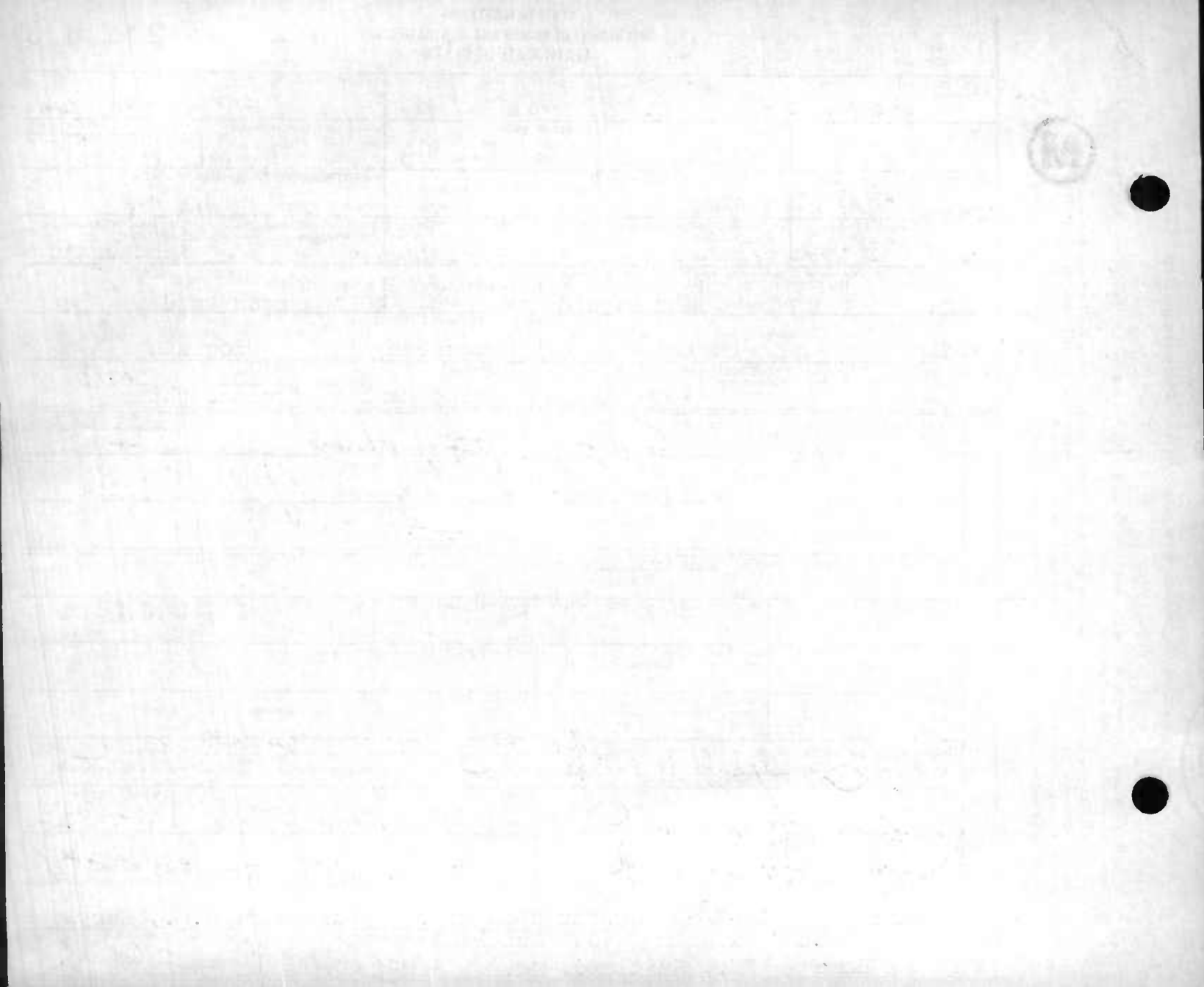
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 6 8 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNARD D. MELLA				2a. DATE OF DEATH MONTH DAY YEAR 12-4-82			
3 SEX MALE		4 RACE Filipino		5. DATE OF BIRTH MONTH DAY YEAR 8-20-93		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PHILIPPINES		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONT GUMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SYLVAN MANOR HEALTH CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Md.				13b. COUNTY PG		13c. CITY OR TOWN Morningside	
14. FATHER'S NAME FIRST MIDDLE LAST Zoilo Mella				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Toribia Diogenis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-07-273		17. INFORMANT Same as 13a 20746 Elaine Canlas, Granddaughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) <u>Cardio-vascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction of the</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Coronary</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>				APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 72</u> to <u>Dec 4</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Jan 72</u> 19 <u>82</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.							
22b. SIGNATURE <u>Benjamin Horowitz</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-4-82	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Horowitz				23b. ADDRESS 3720 Farnsworth Ave. New Md 20855			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-7-82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland	
24. FUNERAL DIRECTOR NAME Robt E Wilhelm				25a. DATE REC'D. BY REGISTRAR DEC 13 1982			
25b. REGISTRAR'S SIGNATURE Funeral Home Rd., Suitland, Md.				25c. REGISTRAR'S SIGNATURE John J. Connel			



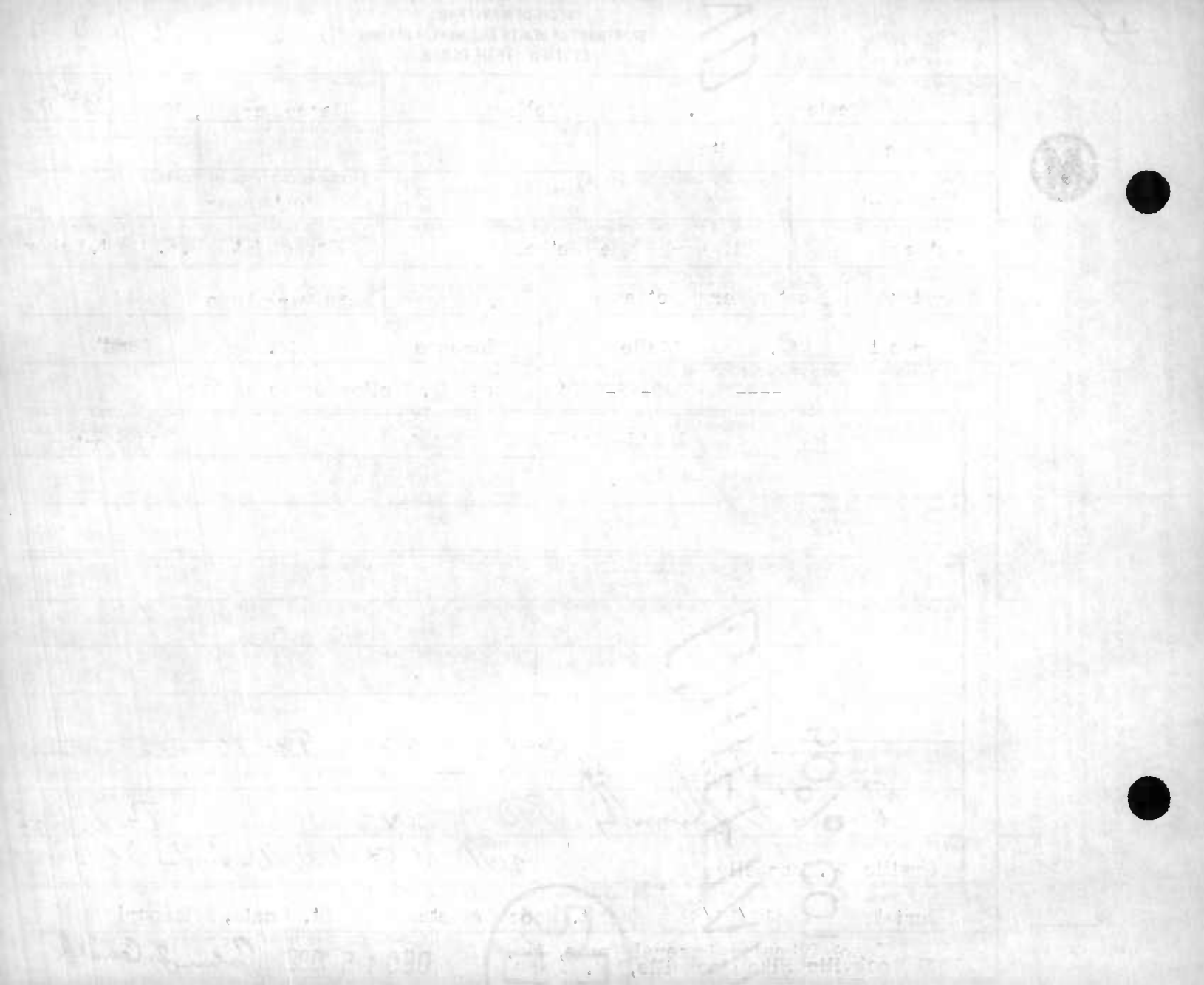
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Wesley S. Mellow					2a. DATE OF DEATH December 10, 1982			2b. HOUR 1044 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 6 DAY 10 YEAR 1949		6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8013 Park Lane Bethesda				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) Economist U.S. Dept. Labor		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8013 Park Lane 20814		
14. FATHER'S NAME FIRST Ernest MIDDLE W. LAST Mellow					15. MOTHER'S MAIDEN NAME FIRST Florence MIDDLE M. LAST Hohlt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 440-48-0654		17. INFORMANT ADDRESS Susan D. Mellow same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1729 IMMEDIATE CAUSE (a) MALIGNANT MELANOMA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 Months	
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF INJURY, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 19 82, to Dec 10, 19 82, that (I) (we) lost saw the deceased alive on Dec 9, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Orville W. Donnelly MD					22c. DATE SIGNED Dec 11, 1982			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Orville W. Donnelly					22f. ADDRESS 2141 K ST NW, Washington D.C. 20037				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/15/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE St. Louis, Missouri	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852					25a. DATE REC'D. BY REGISTRAR DEC 15 1982				
					25b. REGISTRAR'S SIGNATURE John J. Carver				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 0 8 5

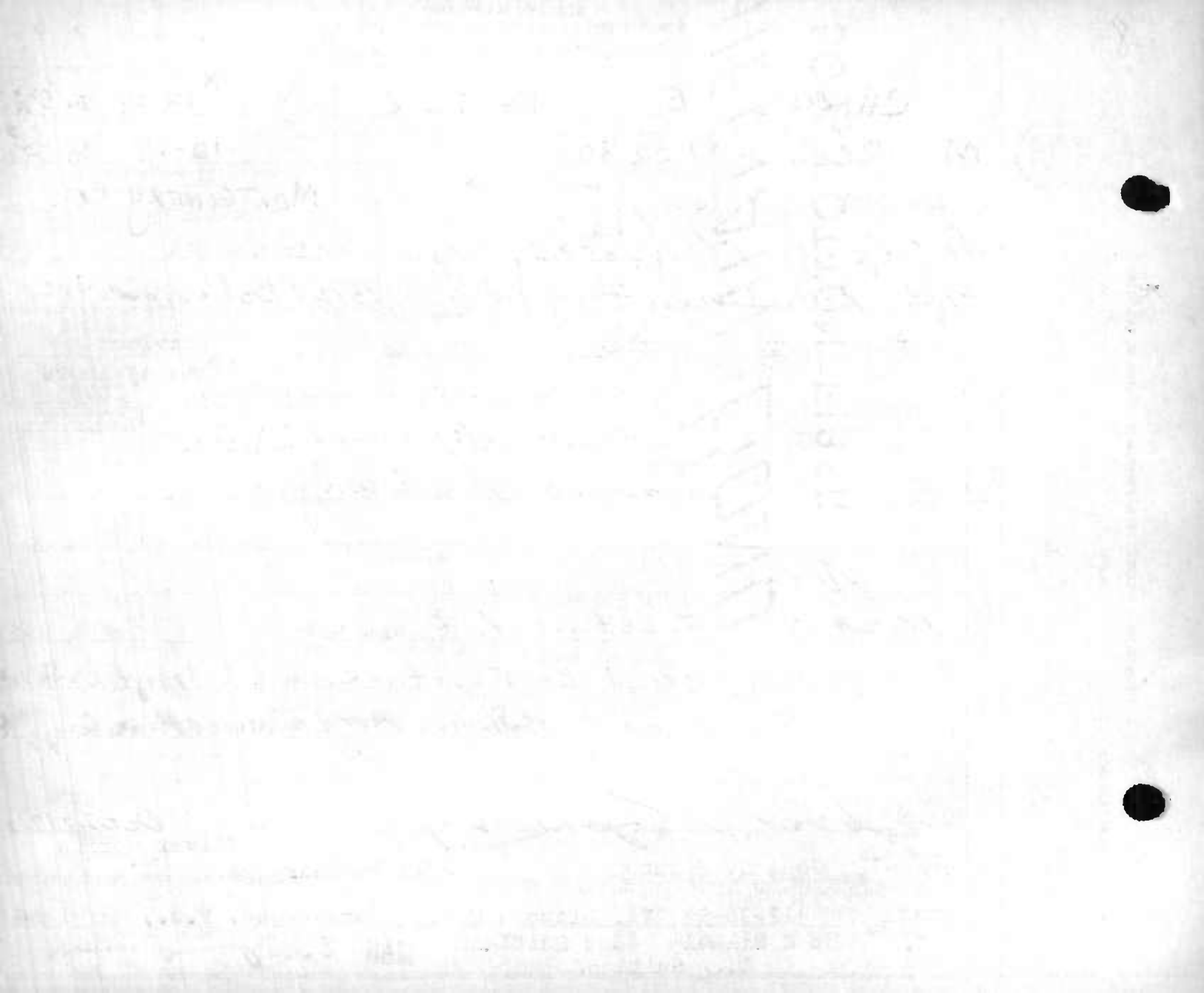
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ZABELLE M. MESROBIAN			2a. DATE OF DEATH MONTH DAY YEAR DEC. 13, 1982		2b. HOUR 11:20^P
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 10 1895	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md. 20815	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 7410 Conn. Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST (Unknown) Martmanian		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nectar (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-84-4933	17. INFORMANT ADDRESS Ara Mesrobian. Same as item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4349 IMMEDIATE CAUSE (a) Cerebral Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hrs. 5 Yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/23 , 19 73 , to 12/13 , 19 82 , that (I) (we) lost saw the deceased alive on 12/4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Robert V. Choisser		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec. 14, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert V. Choisser, M.D.		22e. ADDRESS 5530 Wisconsin Avenue-Chevy Chase, Md. 20815			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 1		23b. DATE 12/17/1982	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.			25a. DATE REC'D. BY REGISTRAR DEC 20 1982		
			25b. REGISTRAR'S SIGNATURE John J. Lough		

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 2 0 8 6	
1. DECEASED NAME (TYPE OR PRINT) CHARLES E METTLER						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12-27 19 82		2b. HOUR 5:55 A M			
3. SEX M	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 3-07-02 80 YRS.	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 12-27 19 82		2d. HOUR 9:45 A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.					
10. CITY OR TOWN OF DEATH Sit. Sp.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - GSA		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md 13b. COUNTY Prince Georges 13c. CITY OR TOWN Landover						13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 3127 Bellevue Ave			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Earl Mettler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Vanvleck								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. 578-18-0263		17. INFORMANT ADDRESS Same as Above		17b. 20785				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1029 IMMEDIATE CAUSE (a) Acute Myocardial Inf DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Carcinoma Lung DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None											
19a. DATE OF OPERATION 11-20-82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture L. Femur				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11 8 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fractured while helping to bath						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Bellevue Ave Landover Prince Georges Md						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers M.D.			TITLE (SPECIFY) Silver Spring			DATE SIGNED Dec 27 1982					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers			ADDRESS 1919 Seminary Rd., Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-30-82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland				
24. FUNERAL DIRECTOR NAME Robt E Wilhelm			4308 Suitland			25a. DATE REC'D. BY REGISTRAR JAN 5 1983		25b. REGISTRAR'S SIGNATURE John S. Rogers			
Funeral Home Rd., Suitland, Md.											



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

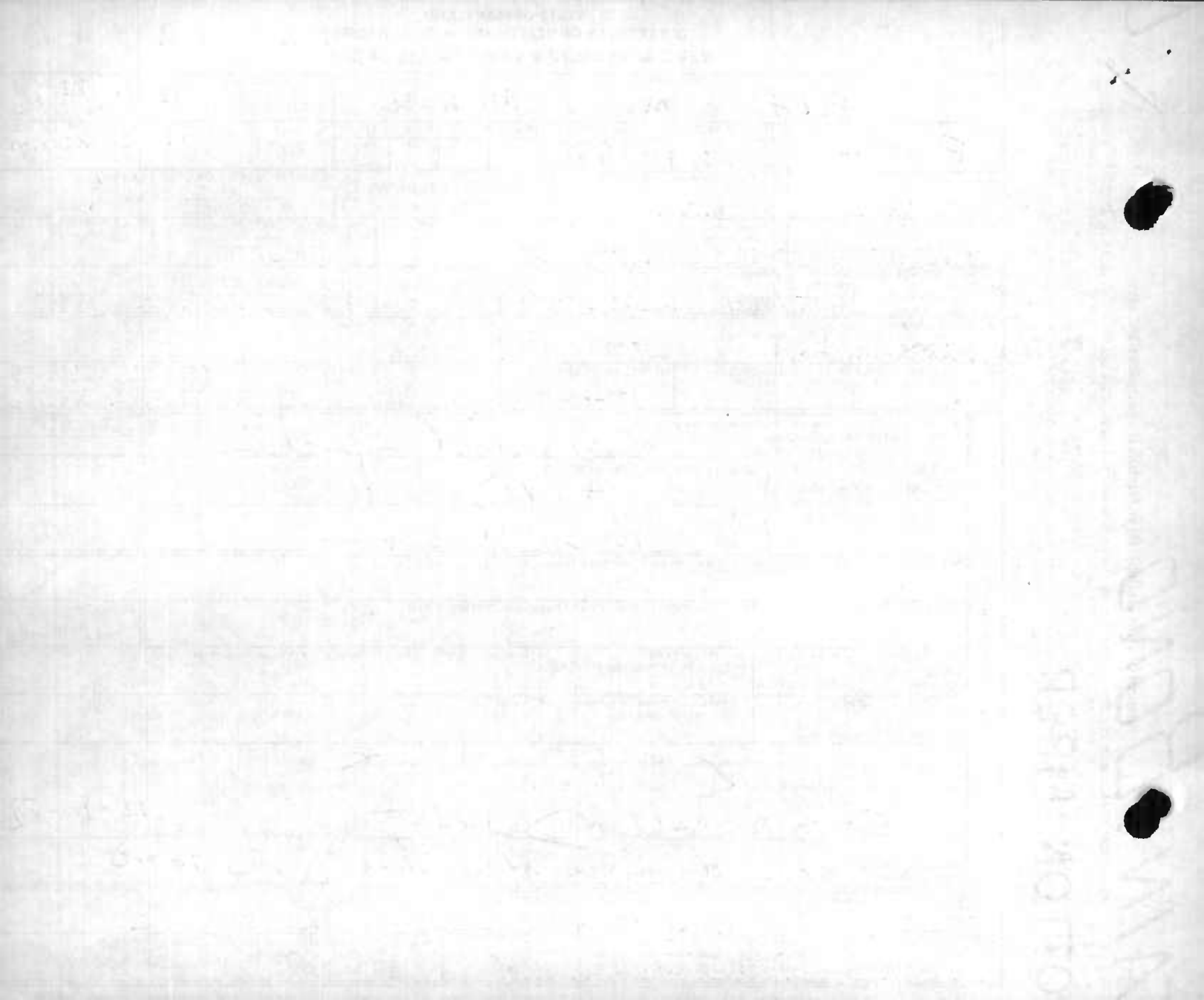
REG. NO.

1- STATE REGISTRAR		2		3		2		8		8		7	
1. DECEASED NAME (TYPE OR PRINT) ELLA M. Michaels										2a. DATE KNOWN OF DEATH MONTH 12 DAY 31 YEAR 1982		2b. HOUR 1P	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH SEPT DAY 10 YEAR 1896		6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH 12 DAY 31 YEAR 1982		2d. HOUR 1.45			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY							
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1020 UNIV. BLVD., EAST				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1020 UNIV. BLVD., EAST 20903					
14. FATHER'S NAME FIRST Michael MIDDLE WARGO LAST WARGO				15. MOTHER'S MAIDEN NAME FIRST ANNA MIDDLE HILLAN LAST HILLAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 177-12-4340		17. INFORMANT DAUGHTER		ADDRESS 8819 GLENVILLE RD SILVER SPRING, MD. 20901							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF ASVD Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE SAW A. DARRIN				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) 5632 annapolis Rd				ADDRESS Bladensburg MD 20710				DATE SIGNED 12-31-82					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/5/83		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.							
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR JAN 6 1983		25b. REGISTRAR'S SIGNATURE John J. Connel					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 3 2 6 8 8			
1 - FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mildred Catherine Miller						2a. DATE OF DEATH MONTH DAY YEAR December 24, 1982				2b. HOUR 4:25P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 12, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 64		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) 2812 Radius Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Walter L. Sullivan						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Virginia Griffin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 223-14-8559		17. INFORMANT DAUGHTER EVELYNE A. TIMBERLAKE		ADDRESS 2812 RADIUS ROAD WHEATON, MD. 20902							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) metastatic colon carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/24, 19 82, to 12/24, 19 82, that (I) (we) lost saw the deceased alive on never 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Mark S. Rosen MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/25/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Rosen				22e. ADDRESS Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/28/82		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY				23d. LOCATION ROCKVILLE MONT MD. STATE					
24. FUNERAL DIRECTOR FRANCIS J. COLLINS NAME ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR DEC 29 1982		25b. REGISTRAR'S SIGNATURE John J. Collins					

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Figure 2

2000

10-10-10

1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 26

2022

0228-41-233

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1600.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 2 3 2 5 8 9									
FOR 1. STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY LOUISE MOHL						2a. DATE OF DEATH MONTH DAY YEAR December 21, 1982		2b. HOUR 4 A M	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1940		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Laytonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6803 Sunset Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD. 20879				13b. COUNTY Montgomery		13c. CITY OR TOWN Laytonsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 6803 Sunset Drive									
14. FATHER'S NAME FIRST MIDDLE LAST Albert - Taylor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel - Brooks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 036-26-5435		17. INFORMANT ADDRESS Roger K. Mohl Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1919 IMMEDIATE CAUSE (a) Ca of Brain DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/1 19 82 , to 12/21 19 82 , that (I) (we) last saw the deceased alive on 7/30 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE R. R. R. R.				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Greger				22e. ADDRESS 12105 Darcystown Rd Gaithers.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Dec. 24 1982		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE E. PROVIDENCE PROV. R. ISLAND			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR DEC 28 1982		25b. REGISTRAR'S SIGNATURE John J. Canfield			

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RIGHTS DIVISION
SALT LAKE CITY, UTAH

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

DATE: [illegible]
BY: [illegible]

RE: [illegible]

[illegible handwritten text]

[illegible handwritten text]

[illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 8 9 0

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joy E. Mohr			2a. DATE OF DEATH: MONTH December DAY 8 YEAR 1982		2b. HOUR 7:45 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH March DAY 30 YEAR 1925		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS 6 Cherbourg Court			20854		
14. FATHER'S NAME FIRST Louis MIDDLE Clement LAST Serpico			15. MOTHER'S MAIDEN NAME FIRST Dorothy MIDDLE LAST D'Arcy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 156-22-4831		
17. INFORMANT William D. Mohr, Husband, Same as item #13			ADDRESS 		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5150 IMMEDIATE CAUSE (a) Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia		3 days
DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Fibrosis		20 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/3 19 78 , to 12/8/82 , that (I) (we) lost saw the deceased alive on 12/8/82 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Robert C. Macon M.D.		DEGREE M.D.	22c. DATE SIGNED 12/8/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Macon		22e. ADDRESS 809 Viers Mill Rd. Rockville, Md 20851	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 11, 1982	23c. NAME OF CEMETERY OR CREMATORY Norbeck Memorial Park	23d. LOCATION CITY OR TOWN Olney COUNTY Maryland STATE
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 13 1982	25b. REGISTRAR'S SIGNATURE

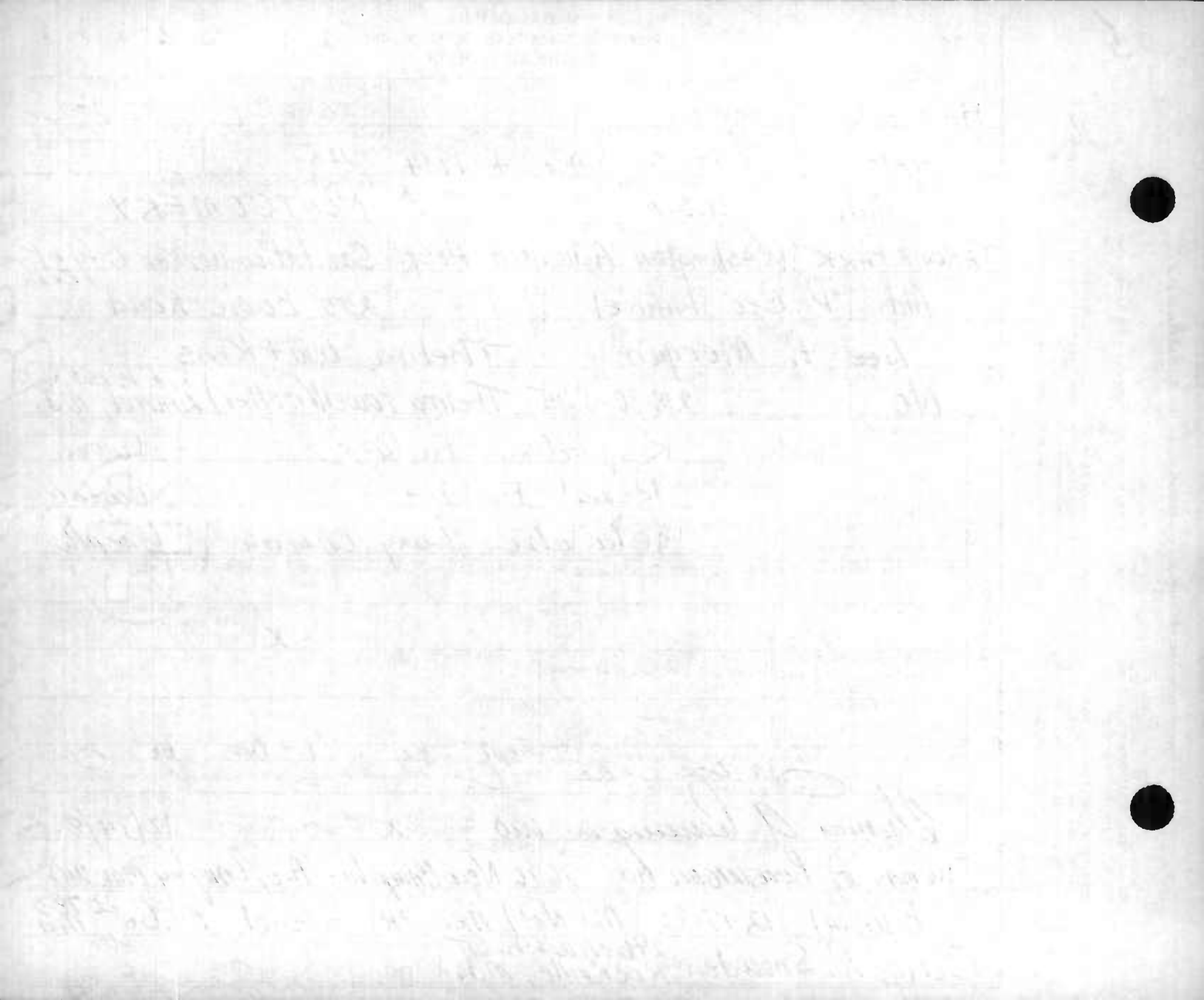
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold G. Morgan					2a. DATE OF DEATH MONTH DAY YEAR Dec. 14 1982			2b. HOUR 2:55 M	
3. SEX Male		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1934		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sanitation worker City of Bowie		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Pr. Geo		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 255 Bowie Road	
14. FATHER'S NAME FIRST MIDDLE LAST Lee P. Morgan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Watkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218-30-8215		17. INFORMANT ADDRESS Thelma Powell (mother) 814 West St. Laurel, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Lung Cancer 60400								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 PM 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 15 Sept. 1982 to 14 Dec. 1982 , that (I) (we) last saw the deceased alive on 13 Dec. 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (a) (b) (c) (d) (did not view the body after death).									
22b. SIGNATURE Thomas A. Bennington MD					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bennington MD					22e. ADDRESS 7676 New Hampshire Ave, Langley Park MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-17-82		23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY Laurel, Pr. Geo Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden			24b. ADDRESS 246 N. Wash. St. Rockville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 17 1982		25b. REGISTRAR'S SIGNATURE John D. Bennington		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1E shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 6 9 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Patricia Morris			2a. DATE OF DEATH MONTH DAY YEAR December 5, 1982			2b. HOUR 9:47P M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comptometer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Martin E. Redmond			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret J. Minan			13e. STREET ADDRESS 15304 Spring Meadows Dr. 20874			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 011-01-9014		17. INFORMANT ADDRESS Edward L. Morris, Jr. (Son) 7700 Random Run Lane, Falls Church, Va. 22042					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINS. 30 MINS. 20 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CARCINOMA OF COLON									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DEC 3 , 19 82 , to DEC 5 , 19 82 , that (I) (we) lost saw the deceased alive on DEC 3 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (each) did not view the body after death.									
22b. SIGNATURE Joseph D. Connor, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec. 6, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph D. Connor, M.D.			22e. ADDRESS 9420 Old Georgetown Road Bethesda, Maryland 20814						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE December 9,		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland			25a. DATE REC'D. BY REGISTRAR DEC 8 - 1982			25b. REGISTRAR'S SIGNATURE John J. [Signature]			

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TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
DATE: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or letter body.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

FOR 1. STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 3 2 6 9 3 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH
Jessie M Mount					MONTH DAY YEAR 2b. HOUR
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		Caucasian		MAR 23 1911	
6. AGE (IN YEARS LAST BIRTHDAY)		7. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
71 YRS.		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Kensington		Kensington Gardens Nursing Home		House wife	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS	
Maryland		Montg		3000 McComas Ave	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Ellis M Muther		ROBERTA M Muther		None	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
151-28-1921		MARY DAVIS		Fairway Ave SS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Tongue</u> 1419 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>CHRONIC BRAIN SYNDROME</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
11/3/82		CARCINOMA OF TONGUE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2 YEARS</u> 19 <u>82</u> to <u>12/7</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11/9</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.		22b. SIGNATURE Ralph M. Coan M.D.		22c. DATE SIGNED 12/7/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
RALPH M. COAN M.D.		4400 EAST WEST HWY, BETHESDA, MD. 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		12-8-82		Cedar Hill Crematory	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. W. CHAMBERS CO. 8655 Ga. Ave., S.S. Md. 20910		DEC 10 1982		John S. Chambers	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 3 2 6 9 4			
1. DECEASED NAME (TYPE OR PRINT) Helen D. Muir				2a. DATE OF DEATH MONTH DAY YEAR 12-10-82			
3. SEX Female				2b. HOUR 7:14 PM			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-3-09		6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Augustus Dapray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen --- Cassin		13e. STREET ADDRESS 5100 Dorset Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-18-2169		17. INFORMANT ADDRESS Brockett Muir-5100 Dorset Ave, Chevy Chase, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Uncertain
DUE TO, OR AS A CONSEQUENCE OF (b) 1539							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pulmonary Embolism							
19a. DATE OF OPERATION 12-8-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-10-82 to Dec 10, 1982 , that (I) (we) last saw the deceased alive on 12-10-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE James W. Egan		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-11-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. EGAN		22e. ADDRESS 5413 Cedar Ln.-206 c Bethesda, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/13/82		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Barnesville, Maryland	
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Inc.				25a. DATE REC'D. BY REGISTRAR DEC 16 1982		25b. REGISTRAR'S SIGNATURE James J. Cassin	
24. FUNERAL DIRECTOR 1530 Wisconsin Avenue, N.W.-Washington, D.C.							

210 Lincoln Avenue, N.E.-Washington, D.C.
L.C. Carter's Sons, Inc.
12/15/52

12/15/52
L.C. Carter's Sons, Inc.
Washington, D.C.

John

Washington Navy Yard

John

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John

2015

Washington Navy Yard

2100 Potomac Avenue

Washington, D.C.

John

John

John

CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James T. Munday		2a. DATE OF DEATH MONTH DAY YEAR 12 21 82		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 26 12		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.
10. CITY OR TOWN OF DEATH Germantown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14121 DARNESOTOWN Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.		13b. COUNTY MONTG.	13c. CITY OR TOWN Germantown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles S. Munday		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Humphries		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-26-6213		17. INFORMANT ADDRESS MARTIN Munday - Jefferson Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) coronary heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mins 2 YRS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 10-22, 19 80 , to 12-30, 19 82 , that (I) (we) last saw the deceased alive on 12-30, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
22b. SIGNATURE Thomas G. Sinderson, MD		DEGREE MD		22c. DATE SIGNED 12-21-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERSON, MD		22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/82	23c. NAME OF CEMETERY OR CREMATORY Parkland	23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg Md.
24. FUNERAL DIRECTOR NAME W. C. Helt		ADDRESS Barnesville Md.		25a. DATE REC'D. BY REGISTRAR DEC 28 1982
				25b. REGISTRAR'S SIGNATURE John J. Conner

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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THE UNIVERSITY OF CHICAGO
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THE UNIVERSITY OF CHICAGO
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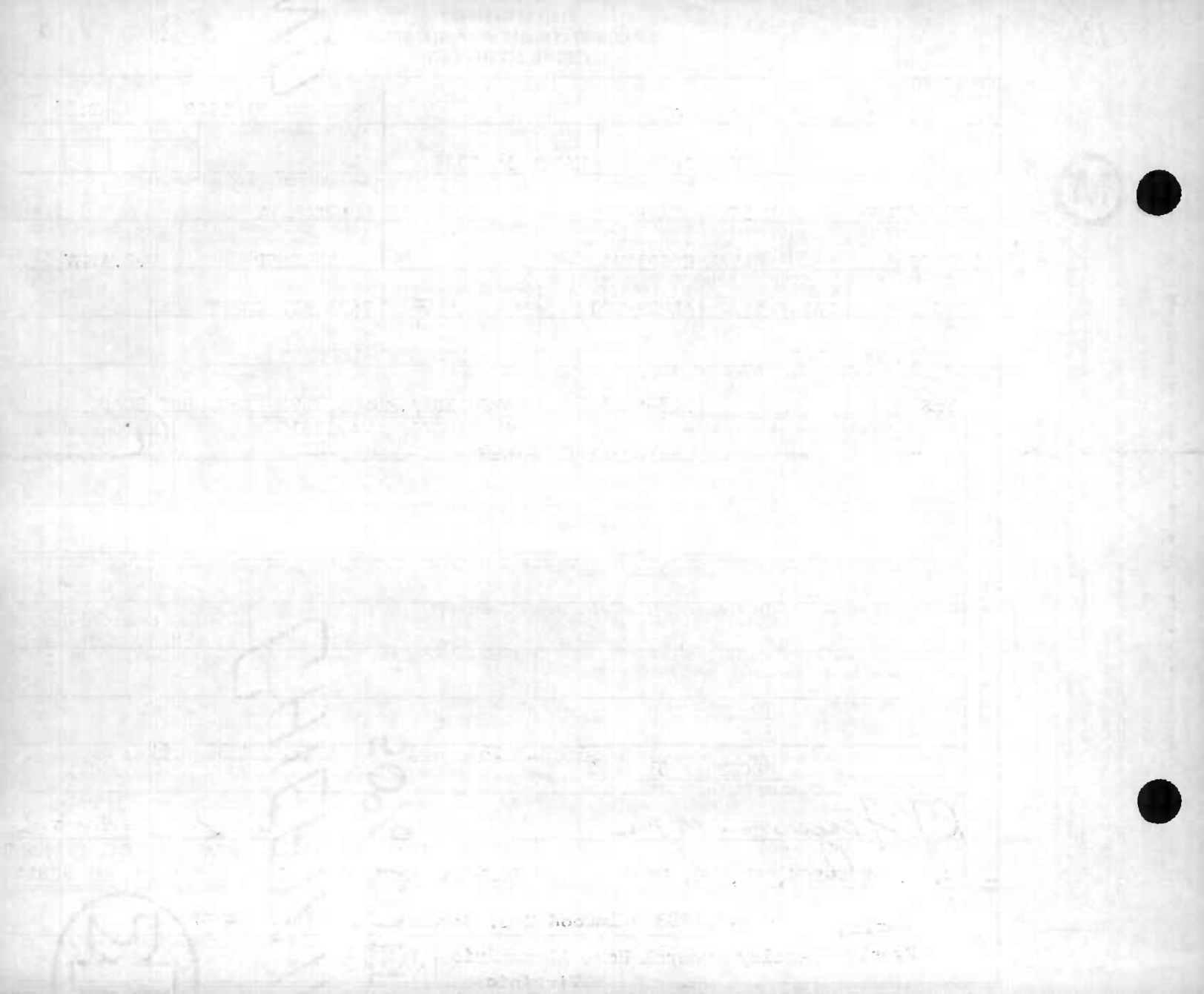
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 6 9 6			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) BENJAMIN LEE MUNOZ				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 31 1982		2b. HOUR 2:55 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 16 1936		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW MEXICO		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	
13a. STATE VIRGINIA		13b. COUNTY FAIRFAX		13c. CITY OR TOWN ALEXANDRIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN MUNOZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY DOUGHTY		16. SOCIAL SECURITY NO. 525-68-5840			
17. INFORMANT ADDRESS MARJORIE A. MUNOZ, 7623 KINGSBURY ROAD,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) PANCREATIC CANCER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 26, 1982 , to DECEMBER 31, 1982 , that (I) (we) last saw the deceased alive on DECEMBER 31, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>RK Ferguson</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3 JAN 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. K. FERGUSON, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 6, 1983		23c. NAME OF CEMETERY OR CREMATORY Elmwood Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Abilene, Texas	
24. FUNERAL DIRECTOR NAME Everly-Wheatley Funeral Home Alexandria Virginia				25. DATE RECEIVED BY REGISTRAR JAN 10 1983			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 6 9 7			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Ray R. Murdock				12 15 82			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 6 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Utah		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10500 Rockville Pike		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY Law	
13a. STATE Md. 20852		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Orrice Abram		15. MOTHER'S MAIDEN NAME Lucinda Robinson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		16b. SOCIAL SECURITY NO. 577-18-9245	
17. INFORMANT Mary M. Christensen		ADDRESS Chevy Chase, Md. 4840 Langdrum La.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Upper Gastrointestinal Bleeding - peptic ulcer disease</u> 5188 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory failure - chronic + recurrent since 2 weeks.</u> (c) <u>Severe Chronic Asthma. Pulmonary disease 10 years.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Chronic organic brain syndrome (not saying temporal cause).</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		21d. I certify that (I) (this hospital) attended the deceased from <u>Sept 21</u> , 19 <u>82</u> , to <u>12</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Sept 21</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22a. SIGNATURE James Morgan O'Donoghue M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Morgan O'Donoghue, M.D.		22e. ADDRESS 3301 New Mexico Ave. N.W. Wash., D.C. 20016		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial / Removal		23b. DATE 12/19/1982	
23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Beaver Utah		24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D. C.		25a. DATE REC'D. BY REGISTRAR DEC 20 1982	
25b. REGISTRAR'S SIGNATURE John J. Connel							

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Yes	Will	517-18-9245	May M. Christensen 4840 Langdon Dr.	Rockville	Montgomery	Rockville	10300	Rockville Pike	Rockville	Law	Montgomery	74	1908	White	U. S. A.	x	Utah
Gracie	Abram	Irishbrook	Irishbrook	Rockville	Montgomery	Rockville	10300	Rockville Pike	Rockville	Law	Montgomery	74	1908	White	U. S. A.	x	Utah

CH 11

Serial Removal 12/19/83 Mountain View Cemetery
 Joseph J. Jones Inc.
 5130 Mac... Ave., N.W. Wash., D.C.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 6 9 9			
1. DECEASED NAME				2a. DATE OF DEATH				REG. NO.			
(TYPE OR PRINT)				MONTH DAY YEAR				2b. HOUR			
JULIA MYERS				12 8 82				10:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		MONTH DAY YEAR MAY 2 1917		65 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PENNA		U.S.A				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		7701 CARROLL AVENUE				HOMEMAKER					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD		MONT.		TAKOMA PARK		YES <input type="checkbox"/> NO <input type="checkbox"/>		701 CHANEY DRIVE			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST JOSEPH ISLIM				FIRST MIDDLE LAST N/A							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				579-32-4120		KENNETH G. MYERS. 701 CHANEY DRIVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 6954 DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CORONARY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>LUPUS ERYTHEMATOSUS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7-10 yrs 7-10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pacemaker - Mitral Valve Prolapse Syndrome</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
March 1976		Permanent Pacemaker		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>Jan 1984</u> , to <u>12-8</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>9-29</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
R.H. Sandstrom M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				12-8-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
R.H. Sandstrom MD				7701 Carroll Ave Takoma Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		Dec. 13, 1982		Folk Lincoln Cemetery		Brentwood, P.G. MD					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS Takoma Funeral Home 254 CLEMENT ST NW DC				DEC 13 1982				John J. Connelley			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 7 0 0				
1 - FOR STATE REGISTRAR										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) JAKOB					FIRST Jakob MIDDLE LAST Nahm					2a. DATE OF DEATH MONTH DAY YEAR 12 18 82			2b. HOUR 8:50A M	
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 14 1894			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MAINZ, West Germany			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Nursing & Con. Center					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician			12b. KIND OF BUSINESS OR INDUSTRY Medicine			
13a. STATE Md. 20815			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7005 West Greenvale Parkway				
14. FATHER'S NAME FIRST MIDDLE LAST Jakob Nahm					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marguerite Hollmann									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-44-2819		17. INFORMANT ADDRESS Doris Nahm. Same as item 13.									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4349 Cerebral Infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks				
IMMEDIATE CAUSE (a) Diffuse Arteriosclerosis										5 years				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellites														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 81 19 Dec. 17 to Dec. 18 19 82 , that (I) (we) last saw the deceased alive on Dec. 17 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Richard B. Perry						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/18/1982				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard B. Perry, M.D.						22e. ADDRESS 1145--19th St., N.W. Wash., D.C. 20002								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/29/1982		23c. NAME OF CEMETERY OR CREMATORY Main Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Mainz Germany						
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc.						ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.		25a. DATE REC'D. BY REGISTRAR DEC 20 1982		25b. REGISTRAR'S SIGNATURE John J. Connel				

MEDICAL CERTIFICATION

2150 Mac...
Joseph...
D.C.

DEC 20 1982

John...
Germany

117-10th St., N.W., Wash., D.C. 20005

12/28/82

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Dec. 18 82

Diabetes Mellitus

Diabetes Mellitus
General Information
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578-4-3119 North Nemo, same as item 15.

John...
Helm...
Hollman

Ms. 20812 Montgomery Chevy Chase

Chevy Chase - Prince & Son, Center, Washington

U.S.A.

John...

John...

VOIDED DEATH CERTIFICATE #⁸²~~85~~-32701

NAME: Sarah H. Napier

DATE OF DEATH: January 15, 1983

PLACE OF DEATH: Montgomery Co.

SEE: Feb., 1983
Death Drawer

DEMH 2485 - Vit. Rec.

[Faint, illegible handwritten text, possibly a signature or address]

1912-1913
1913-1914

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1914-1915

1- FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 2 7 0 2

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR.			8. IF UNDER 24 HRS.			9. DATE PRONOUNCED DEAD			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY		
Scott Kent Naugle			12 MONTH 11 DAY 19 82			Male			white			3-6-1956			26 YRS.			MONTHS DAYS HOURS MIN.						12 13 19 82			Bethesda			7211 Rolling Wood Rd.			Computer Specialist			Computers		
7a. BIRTHPLACE			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH																													
Minnesota			U.S.A.			WIDOWED			Montgomery County																													
13a. STATE			13b. CITY OR TOWN			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS																										
Md.			Montgomery			Chevy Chase			YES			7211 Rollingwood Drive																										
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT																										
John Earl Naugle			Ethel Hale			No			218 68 3663			Chevy Chase, Md. 20815																										
18. CAUSE OF DEATH			PART 1 DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF																													
9805			Multiple drug intoxication																																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?																																
21a. EXTERNAL CAUSE WAS			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED																																
UNDERLYING			? 12/11/82			self ingested																																
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION																																
WHILE AT WORK			Home			7211 Rolling Wood Rd. Bethesda Montg. Co. Md.																																
22a. I certify that I took charge of the remains described above, held an			Autopsy			Inspection			Inquiry			and in my opinion																										
death resulted from:			Natural causes			Accident			Suicide			Homicide			Undetermined manner																							
ACTUAL SIGNATURE			Hormez R. Guard, M.D.			M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED			12-14-82																							
EXAMINER'S NAME			ADDRESS																																			
123a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION																													
Cremation			Dec. 16, 1982			Lee's Crematory			Washington, D.C. 20002																													
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																																
Lee Funeral Home			300-4th St. N.E. Wash. D.C. 20002			DEC 20 1982			John J. Canfield																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERYL E NETTLETON					2a. DATE OF DEATH MONTH DAY YEAR 12 10 82			2b. HOUR 1:58 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 21, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 76		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Drug Control Clerk		12b. KIND OF BUSINESS OR INDUSTRY N.I.H.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9217 Adelaide Drive 20817	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Brand					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Hill				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 476-10-2831		17. INFORMANT 2518 Farnstone Drive Jerome P. Nettleton Wilmington, Del. 19805					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4148 Recurrent Refractory Ventricular Tachycardia & Fibrillation 12 hours DUE TO, OR AS A CONSEQUENCE OF (b) Severe myocardial Ischemia 24 hours DUE TO, OR AS A CONSEQUENCE OF (c) Severe &therosclerotic heart disease Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Old myocardial infarction and chronic ventricular irritability									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1982, to 12-10-1982, that (I) (we) lost saw the deceased alive on 12-10-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph A. Romeo M.D.					DEGREE M.D.		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Romeo M.D.					22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 14 1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR DEC 17 1982		25b. REGISTRAR'S SIGNATURE J. A. J. Conner		

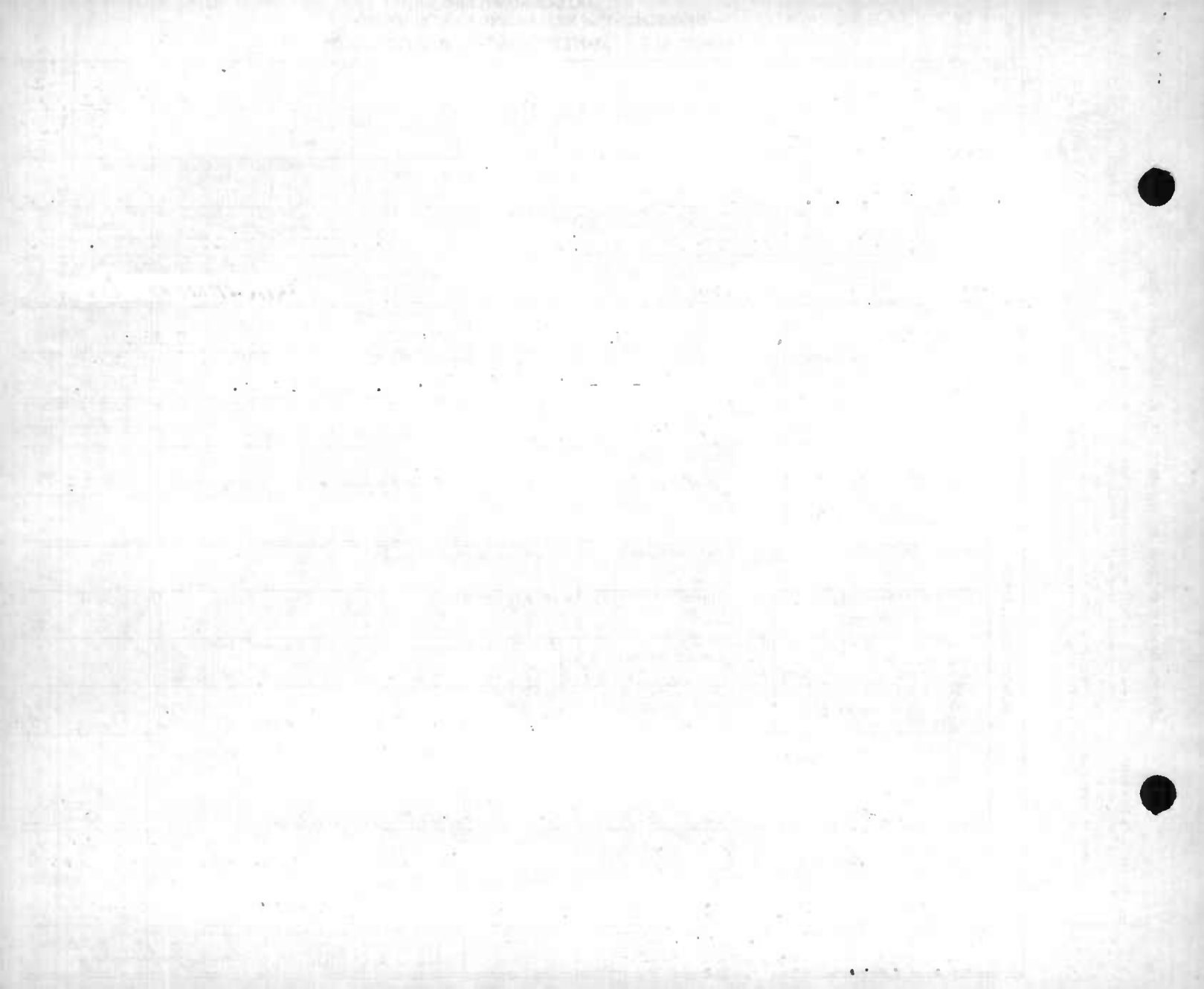
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
FOR 1360374 12/27/82 GAR 2 3 2 7 0 4											
1- STATE REGISTRAR											
I. DECEASED NAME FIRST MIDDLE LAST											
THOMAS E NEWMAN											
2a. DATE KNOWN OF DEATH MONTH DAY YEAR											
12 14 1982											
2b. HOUR OF ESTI. MATED											
726 PM											
3 SEX											
male											
4. RACE											
CAUC											
5. DATE OF BIRTH MONTH DAY YEAR											
Feb. 23 29 53 YRS.											
6. AGE (IN YEARS LAST BIRTHDAY)											
IF UNDER 1 YR. IF UNDER 24 HRS.											
7c. DATE PRONOUNCED DEAD MONTH DAY YEAR											
12 14 1982											
7d. HOUR											
726 PM											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)											
Washington, D.C. United States											
7b. CITIZEN OF WHAT COUNTRY?											
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
9. BALTIMORE CITY OR COUNTY OF DEATH											
MONTGOMERY Co. MD.											
10. CITY OR TOWN OF DEATH											
BETHESDA											
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
SUBURBAN HOSPITAL											
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)											
Finance Officer											
12b. KIND OF BUSINESS OR INDUSTRY											
Montg. Co.											
13a. STATE											
MD											
13b. COUNTY											
MONTGOMERY											
13c. CITY OR TOWN											
POTOMAC											
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>											
13e. STREET ADDRESS											
Buckhannon Drive 20854											
14. FATHER'S NAME FIRST MIDDLE LAST											
Andrew M. Newman											
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Kathryn Shilenn											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)											
Yes											
16b. SOCIAL SECURITY NO.											
579-34-0880											
17. INFORMANT											
brother											
18. ADDRESS											
101306 Lucksmanor Rd. Rockville, Md 20854											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION											
DUE TO, OR AS A CONSEQUENCE OF											
4100											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) ARTERIOSCLEROTIC CARDIOVASCULAR Dis											
DUE TO, OR AS A CONSEQUENCE OF											
UNDOT											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR											
6 P.M. 12 15 1982											
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
COLLAPSED IN STORE											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK											
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)											
STORE											
21f. LOCATION CITY OR TOWN COUNTY STATE											
CABIN JOHN MALL POTOMAC MONTGOMERY MD											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE											
TITLE (SPECIFY)											
M.D. Sept											
MEDICAL EXAMINER											
DATE SIGNED											
12/15/82											
EXAMINER'S NAME (TYPE OR PRINT)											
Francis C. Mayne											
ADDRESS											
8200 Wisconsin Ave Bethesda MD 20814											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)											
Burial											
23b. DATE											
18, 1982											
23c. NAME OF CEMETERY OR CREMATORY											
Monocacy Cemetery											
23d. LOCATION CITY OR TOWN COUNTY STATE											
Beallsville Maryland											
24. FUNERAL DIRECTOR NAME ADDRESS											
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland											
25a. DATE REC'D. BY REGISTRAR											
DEC 20 1982											
25b. REGISTRAR'S SIGNATURE											
John J. Conner											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 0 5

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOURS MIN.	
NELLYE Irving NICHOLS		12 5 82		3:17 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	63 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Maryland		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	
Montgomery Co., MD.		Rockville		Shady Grove Adventist Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	
Housewife				13a. STATE 13b. COUNTY 13c. CITY OR TOWN	
				Maryland Montgomery Gaithersburg	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
Irving Ballenger 20878		Nellie Burdette		No	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mable Sizemore, 22404 Clarksbury Rd. Boyds, Md. 20841		PART 1. DEATH WAS CAUSED BY:		30 min	
		IMMEDIATE CAUSE (a) Cardiac arrest			
		DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease		20 yrs	
		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
Diabetes mellitus - insulin dependent					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from Dec 4, 1982, to Dec 5, 1982, that (we) last saw the deceased alive on Dec 4, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Michael A. Greene, MD		MD		12/5/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
Michael A. Greene, MD		19271 Montgomery Village, Gaithersburg		John J. Conner	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Dec. 8, 1982		Monocacy	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ulin L. Molesworth, P.A., Damascus, Md.		DEC 9 1982		John J. Conner	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) BABY BOY NICOL						2a. DATE OF DEATH MONTH DAY YEAR Feb. 20, 1982		2b. HOUR 7:36am	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 20, 1982		6. AGE (IN YEARS LAST BIRTHDAY) 35 minutes YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mont.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY ✓ MONT.		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7520 MAPLE AVE. #202	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM WILFRED NICOL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSEMOND K. COLE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Patients Chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7610 Prematurity 24 weeks DUE TO, OR AS A CONSEQUENCE OF (b) Premature rupture of membrane DUE TO, OR AS A CONSEQUENCE OF (c) Incompetent cervix									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N / A					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Arminia Garza H.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1-23-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARMINIA GARZA				22e. ADDRESS WASHINGTON ADVENTIST HOSP.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON ADVENTIST		23d. LOCATION CITY OR TOWN COUNTY STATE Takoma Park Mont. MD			
24. FUNERAL DIRECTOR NAME ADDRESS HERBERT Z. SHIROMA: 7600 CARROLL AVE. TAKOMA PARK, MD									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 7 0 7			
1. FOR STATE REGISTRAR Betty B. Nicolson				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) Betty B. NICOLSON				2a. DATE OF DEATH MONTH DAY YEAR 12 30 82			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 3, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 96	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Beth. Nursing and Ret. Ctr. Receptionist		12a. USUAL OCCUPATION Smithsonian		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE D.C.				13b. COUNTY None		13c. CITY OR TOWN Washington	
14. FATHER'S NAME FIRST MIDDLE LAST George D. Nicolson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalie Micou			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 679-60-0525		17. INFORMANT ADDRESS George D. Nicolson Rt 3 Box 42 Hayes, Va. 23072	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiac Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease			
				DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-16 , 19 81 , to 12-21 , 19 82 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 11-10 , 19 82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.							
22b. SIGNATURE Blaine Fitzgerald				22c. DATE SIGNED 12-21-82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M.D.	
22e. ADDRESS 8218 Wisc. Ave. Beth, Md. 20814				22f. DATE SIGNED BY REGISTRAR DEC 27 1982			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/82		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem.		23d. LOCATION Wash., D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.				25a. DATE RECEIVED BY REGISTRAR DEC 27 1982			
5130 Wisc. Ave. N.W. Wash., D.C. 20016							

Harry H. Robinson

Female

White

Feb. 3, 1988

Montgomery

Virginia

Harry H. Robinson, Jr., Nursing and Ret. Serv. Representative

D.C. Home Washington x 4885 Robert H. W.

George

Robinson

Female

Black

679-61-0325 George H. Robinson Rt 3 Box 45 Evans, Va.

U.S. Marine Hospital, 400 8218 Waco Ave. Waco, TX 76798

12/27/88 Book Creek Camp

Joseph Carter's Home, Inc. 2130 Waco Ave. Waco, TX 76798

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 1 0 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) COYLE E. ELIZABETH NIEBEL				2a. DATE OF DEATH MONTH DAY YEAR December 13, 1982			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 21 14		2b. HOUR 11:45 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY			
13c. CITY OR TOWN KENNINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS APT # 712 3333 UNIV. BLVD., W. 20895			
14. FATHER'S NAME FIRST HARVEY MIDDLE LAST MOUNTZ		15. MOTHER'S MAIDEN NAME FIRST HENRIETTA MIDDLE LAST BRYMESSE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 344-40-9315		17. INFORMANT DR. HAROLD H. NIEBEL ADDRESS SAME AS 13 HUSBAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 4360 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRO VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DEC 9 , 19 82 , to DEC 13 , 19 82 , that (I) (we) last saw the deceased alive on DEC 13 , 19 82 , and that in (my) (our) apianian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M Katikineni		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANGAL KATIKINENI		22e. ADDRESS 3301 NEW MEXICO AVE, N.W. # 328 WASH DC, 20016					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/15/82		23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS		23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM MARYLAND	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 2090		25. DATE RECEIVED BY REGISTRAR DEC 17 1982		26. REGISTRAR'S SIGNATURE John J. Gresh	

DEC 11 1985

2024 COLLEGE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove (detach) pages 1 and 2 and file with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be certified to the State Department of Health and Mental Hygiene.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 7 0 9	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
BERNARD RAY NOYES, Sr.			December 10, 1982						2:30 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		July 28, 1937		45		MONTHS DAYS		HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (IF WORKING)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Washington Adventist Hospital				Dock Worker		Preston Trucking			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS		
Md. 20737 Prince Geo. Riverdale						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5809 63rd Place		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Valderme Noyes			Neva Craigo								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
Yes Korean			217 32 2325			Geraldine Noyes Same as #13 (Wife)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>supine pulmonary embolism during op.</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>supine pulmonary embolism during op.</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>emphysema</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>											
22a. I certify that (1) this hospital attended the deceased from <i>12/9</i> to <i>12/10</i> , 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (If not, view the body after death)											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
<i>Lewis H. Dennis</i>									<i>12/10/82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
Lewis H. Dennis, M.D.			831 University Bl'vd Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			12/13/82		Ft. Lincoln Cemetery		Brentwood P.G. Maryland				
24. FUNERAL DIRECTOR						25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland						DEC 14 1982			<i>John J. Carver</i>		

BP



Male

White

July 22, 1917

42

1917, 1918

Maryland

U.S.A.

x

Prince Georges

Takoma Park

Washington Adventist Hospital

Dock Worker

Preston Trucking

id. 20757

Prince Geo. Riverdale

x

2009 27th Place

Valentine

Noyes

Leva

Craig

Yes

Korean

217 22 2225

217 22 2225 (11/10) Noyes Same as 117 (11/10)

Louis H. Dennis, M.D.

821 University Blvd Silver Spring, Md.

Burial

12/17/82

Dr. Lincoln Temple v. Greenwood, Md. Maryland

Francis G. Galt's Tomb Funeral Home, P.A.
Baltimore, Maryland

P.A.

DEC 14 1982

Francis Galt

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

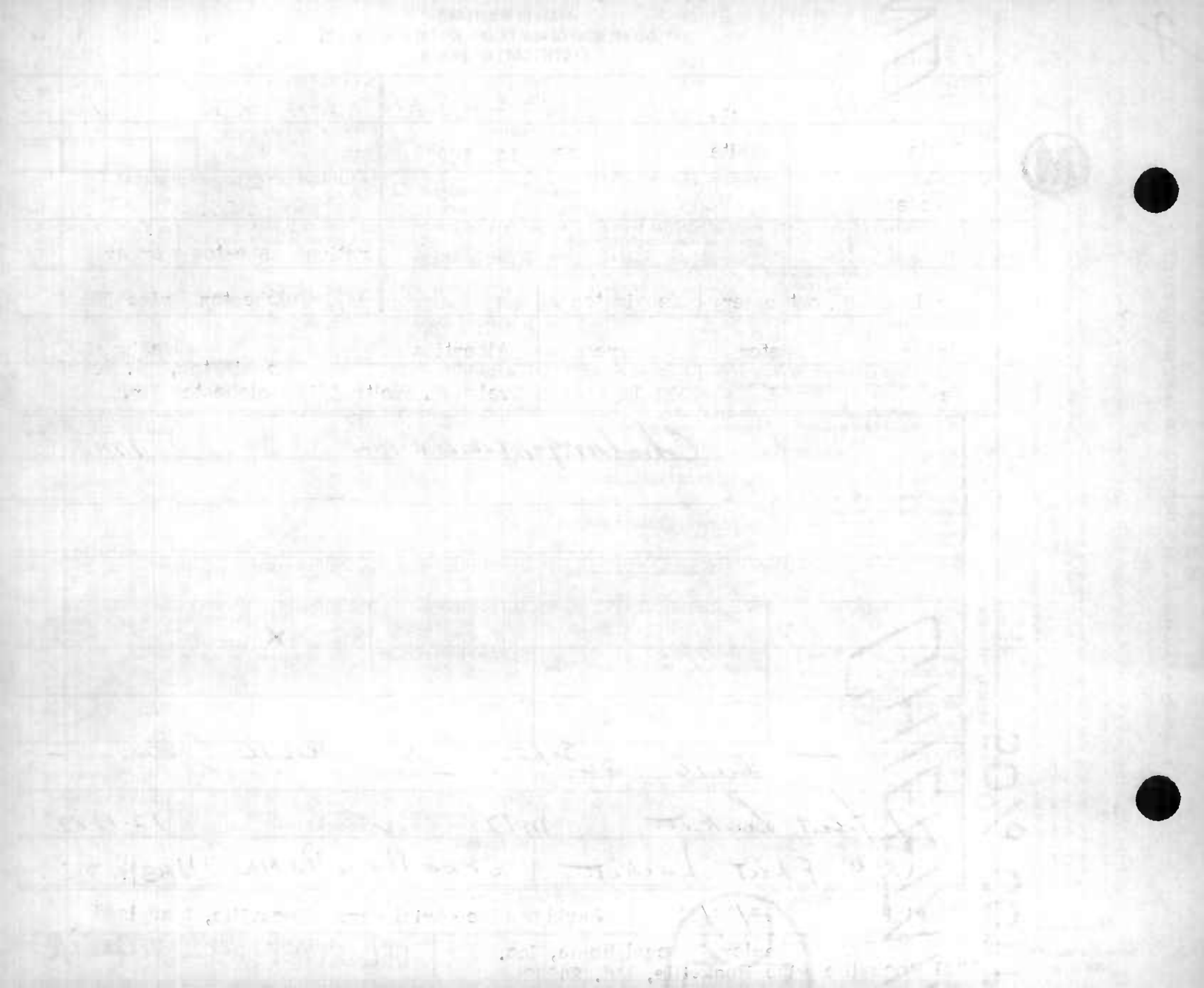
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 1 0			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
3. SEX				4. RACE				5. DATE OF BIRTH			
6. AGE (IN YEARS (LAST BIRTHDAY))				7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				8. BALTIMORE CITY OR COUNTY OF DEATH			
9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				13a. STREET ADDRESS			
13b. STATE				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
16b. SOCIAL SECURITY NO.				17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				21d. INJURY OCCURRED				21e. PLACE OF INJURY			
21f. LOCATION				22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE			
22c. DATE SIGNED				22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
23d. LOCATION				24. FUNERAL DIRECTOR'S NAME				25a. DATE REC'D. BY REGISTRAR			
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S NAME				25d. REGISTRAR'S ADDRESS			
John A. NYGREN				12-16-82				10:30 M			
Male				white				12 TH 13 ^{DAY} 1893 ^{YEAR}			
Sweden				USA				MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
Bethesda				Suburban Hospital				retired asbestos worker			
Maryland				Montgomery				Kensington			
Johan				Peter				Albertina			
Swedlund				Kensington, Md. 20895				Evelyn C. Woltz 4412 Colchester Dr.			
yes				WW I				577 16 6550			
1551				Cholangio carcinoma				17m			
DUE TO, OR AS A CONSEQUENCE OF				DUE TO, OR AS A CONSEQUENCE OF				DUE TO, OR AS A CONSEQUENCE OF			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				21d. INJURY OCCURRED				21e. PLACE OF INJURY			
21f. LOCATION				22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE			
22c. DATE SIGNED				22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Burial				12/20/82				Parklawn Memorial Park Rockville, Maryland			
Tyson Wheeler Funeral Home, Inc.				1331 Rockville Pike Rockville, Md. 20852				DEC 23 1982 John J. Smith			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Thomas

D.

O'Brien

2a. DATE KNOWN
OF DEATH ESTI-
MATED

☒ MONTH DAY YEAR
12/23 19 82

2b. HOUR
M

3. SEX

4. RACE

5. DATE OF BIRTH
MONTH DAY YEAR
Jul. 22, 1898

6. AGE (IN YEARS
(LAST BIRTHDAY)
84 YRS.

IF UNDER 1 YR.
MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.
HOURS MIN.

2c. DATE
PRONOUNCED
DEAD

12/23 19 82

9:58
A. M

7a. BIRTHPLACE (STATE OR
COUNTRY)

PENNA.

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD.

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

1405 Parr Ridge Road

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

RETIRED MILKMAN DELIVER

12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Silver Spring

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

1405 Parr Ridge Road 20868

14. FATHER'S NAME

FIRST

MIDDLE

LAST

THOMAS

O' BRIEN

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

JULIA

GITTING

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

176-26-2268

17. INFORMANT

DONALD O'BRIEN

1405 PARRS RIDGE RD.

SPENCERVILLE, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Acute myocardial disease

4291

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) chronic myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Carcinoma of the intestine

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

None

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

Autopsy ☐Inspection ☐Inquiry ☒

and in my opinion

TITLE (SPECIFY)

M.D. Deputy MEDICAL EXAMINER

DATE SIGNED 12/23/82

ACTUAL SIGNATURE

EXAMINER'S NAME
(TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS

1919 Seminary Road
Silver Spring, Montgomery, Md.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE

12/28/82

23c. NAME OF CEMETERY OR CREMATORY

IMMACULATE CONCEPTION

23d. LOCATION

NEW OXFORD ADAMS

COUNTY

PENNA

24. FUNERAL DIRECTOR

FRANCIS J. COLLINS

500 UNIVERSITY BLVD. WEST
SILVER SPRING, MD

25a. DATE REC'D. BY REGISTRAR

DEC 28 1982

25b. REGISTRAR'S SIGNATURE

John J. Conner

INMATE CONCESSION NEW ORLEANS ARANS TENNA
FRANCIS J. COLLINS
SILVER STREET, LAND WEST

IT IS

THOMAS
O. WATSON
JULIA
CITIZING
1905 THREE THREE TWO
SPECIALTY, W.

LEWIS
U.S.A.
1905

1905

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 1 2

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST JOHN ARTHUR OLEY		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 31 1982		2b. HOUR 10:30 P	
3 SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 10 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5308 GLENWOOD ROAD (Montgomery Hospice)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED Consultant		12b. KIND OF BUSINESS OR INDUSTRY Hospital Admin.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 20014 MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5308 GLENWOOD ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN A. OLEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET K. KOCIMBA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1923-1955		17. INFORMANT ELIZABETH M. OLEY		ADDRESS Bethesda Maryland 5308 GLENWOOD ROAD,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 28, 1982 , to DECEMBER 31, 1982 , that (I) (we) last saw the deceased alive on DECEMBER 31, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>M. Browning</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. BROWNING				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL CMB, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/11/1983		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.				25a. DATE REG. BY JAN 11 1983		25b. REGISTRAR'S SIGNATURE <i>J. Gawler</i>			

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



50074

Insurance

Medical
Admin.

Bedrooms - 4

1500 Ave. N. "Bldg." N.Y.
Joseph D. Miller's son Inc.
1/1/1975 Washington National Bank
Washington Virginia

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. GIVE PAGES 4 AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 3 2 7 1 3			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Felix A O'Quinn										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12 6 82 19		2b. HOUR 8:07a	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01 14 1917		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 65		7. UNDER 24 HRS. MONTHS DAYS HOURS MIN 0 0 0 0		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 6 82 19		2d. HOUR 8:07a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Takoma Park, Md				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dentist				12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. STATE Maryland				13b. COUNTY PG		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3222 Powder Mill Road			
14. FATHER'S NAME FIRST MIDDLE LAST Felix A. O'Quinn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Russell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW 11				16b. SOCIAL SECURITY NO. 437 10 1018		17. INFORMANT ADDRESS Mary G. O'Quinn- wife-(same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) DME				MEDICAL EXAMINER John S. Rogers				DATE SIGNED Dec 6, 1982	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME				ADDRESS 1905 Seminary Road, S.S. Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-9-1982		23c. NAME OF CEMETERY OR CREMATORY Maryland Veteran Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Prince Georges Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi Funeral Home				11800 N.H. Avenue, Sil. Spr. Md. 20904				25a. DATE REC'D. BY REGISTRAR DEC 7 - 1982		25b. REGISTRAR'S SIGNATURE John J. Connelley			

Very G. O'Brien - wife (same as 12a)

1180 W. H. Avenue
Baltimore, Md. 20004
DEC 1 - 1962
Charles E. O'Brien - wife (same as 12a)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 1 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frances Willa Osborne			2a. DATE OF DEATH MONTH DAY YEAR December 14, 1982		2b. HOUR 9:30 p.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 6, 1920	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Pr. George's	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS 10812 Knoll Court (20772)	
14. FATHER'S NAME FIRST MIDDLE LAST Harrison W. Poteat			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel G. Gibson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 229-14-5673	17. INFORMANT ADDRESS Clyde Osborne (Husband) Same as Patient		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Tumor induced Pulmonary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Breast Cancer</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 min 3 weeks 3 years
--	--	---

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 6, 1982</u> , to <u>December 14, 1982</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>December 14, 1982</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE <u>Stanley H. Weiss</u>		DEGREE M.D.		22c. DATE SIGNED 12/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley H. Weiss, M.D.		22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md 20205			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE December 19, 1982	23c. NAME OF CEMETERY OR CREMATORY Hamilton Mawk Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Vanceburg, Louis, Kentucky
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 16 1982	
Old Alexander Ferry Road, Clinton, Maryland			



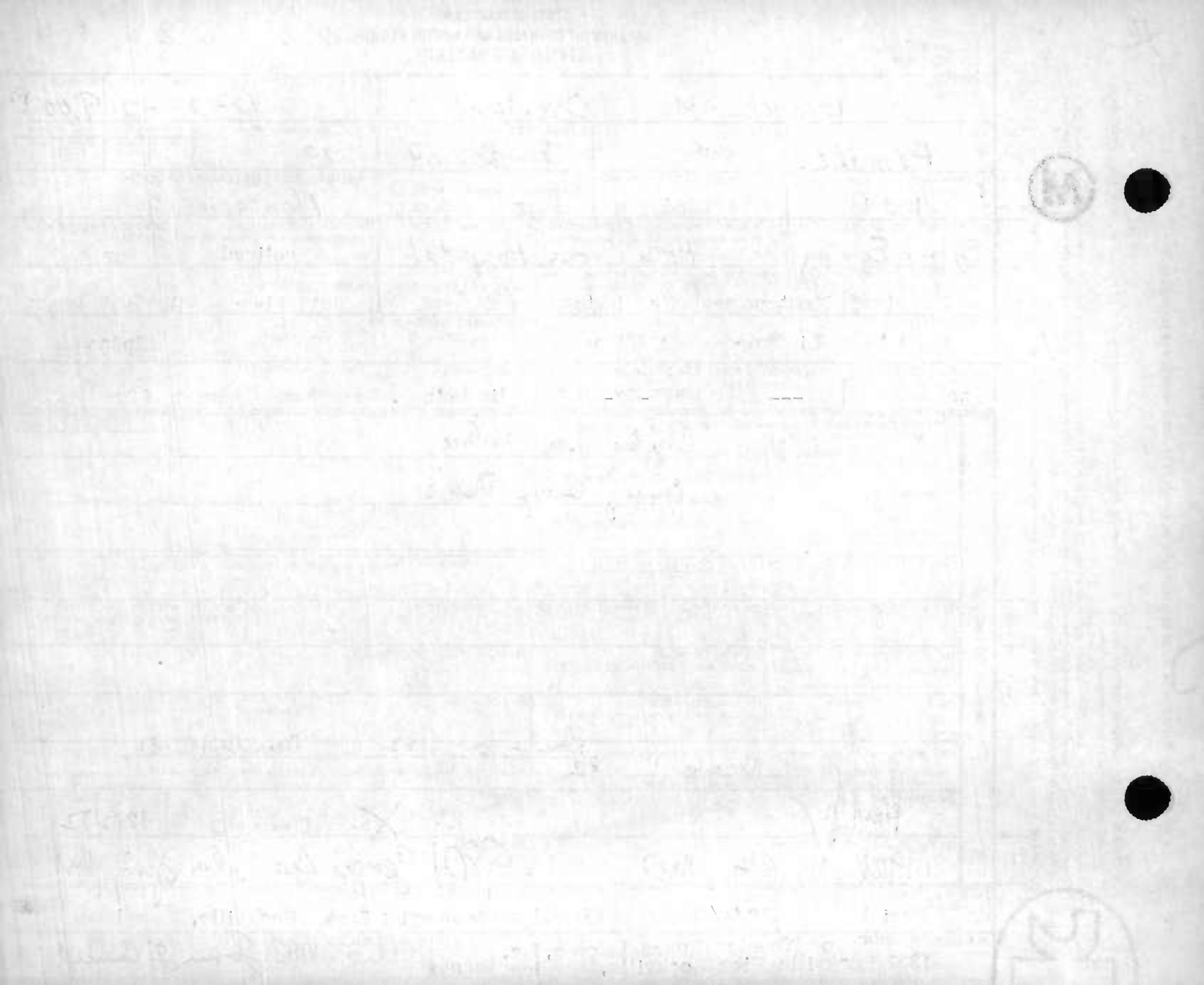
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 3 2 7 1 5						
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH						
Grayce M. Overton					12-1-82 9:00 P.M.						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR			
Female		white		7-30-04		78 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				retired		nurse			
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland					Montgomery		Kensington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
Ernest Lindwood Madison					Mary Edna Lipscomb						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS	
no					---		579-03-7077A			Elizabeth A. Bradshaw same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from November 30, 1982, to December 1, 1982, that (I) (we) last saw the deceased alive on December 1, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE					DEGREE			22c. DATE SIGNED			
MARK H. GIG, M.D.					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			12/2/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
MARK H. GIG, M.D.					9801 Georgia Ave Silver Spring, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12/4/82		Parklawn Memorial Park		Rockville, Maryland					
24. FUNERAL DIRECTOR											
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852											
25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE)											
DEC 8 1982 John J. Carroll											

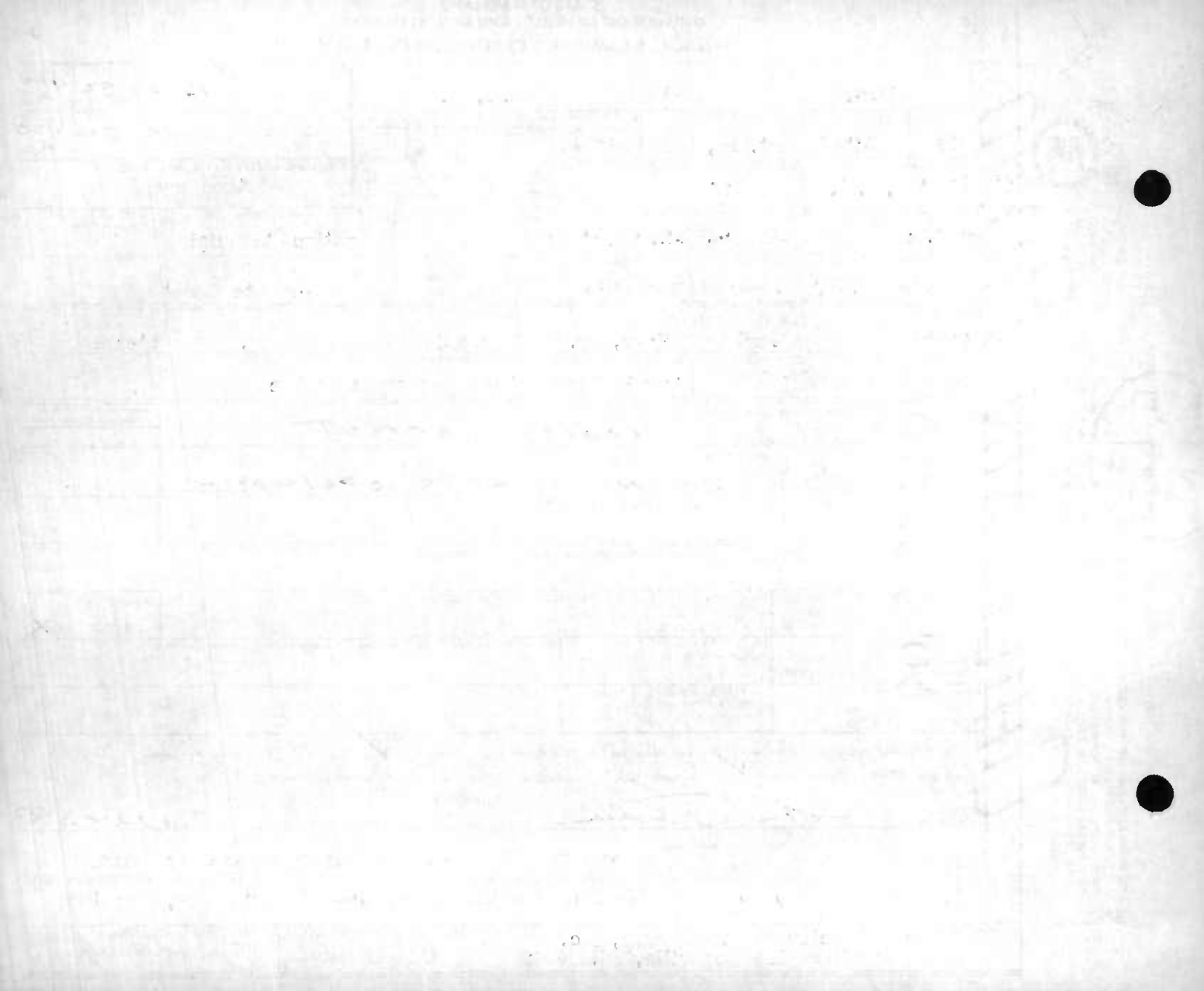
BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, JUDGE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (1))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 7 1 6	
1. DECEASED NAME (TYPE OR PRINT) Richard Earl Page, Jr.										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 12-23-82	
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH Oct. DAY 19 YEAR 1918	6. AGE (IN YEARS) (LAST BIRTHDAY) 64 YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD MONTH 12-23 DAY 32 YEAR 19		2b. HOUR 4:20 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5605 Dowgate Court #202				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired technician		12b. KIND OF BUSINESS OR INDUSTRY TV			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5605 Dowgate Court #202			
14. FATHER'S NAME FIRST Richard MIDDLE Earl LAST Page, Sr.					15. MOTHER'S MAIDEN NAME FIRST Dollie MIDDLE V. LAST Steele						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT ADDRESS Ida Page same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John O. Tauber			TITLE (SPECIFY) John O. Tauber			M.D. _____			DATE SIGNED 12-23-82		
EXAMINER'S NAME (TYPE OR PRINT) John Tauber			ADDRESS 8218 Wisconsin Ave								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/27/82		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery				23d. LOCATION CITY OR TOWN COUNTY Cheltenham, Maryland		
24. FUNERAL DIRECTOR NAME Pyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE John J. Tauber			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 1 7 REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Girair				FIRST Palamoudian LAST xxxxxx				2a. DATE OF DEATH MONTH 12 DAY 13 YEAR 1982 2b. HOUR 2:48 AM			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH Mar. DAY 23 YEAR 1914		6 AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0		YRS. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN SOURCE OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR OCCUPATION House			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE France 13c. CITY OR TOWN Paris, France		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4 Cite							
14 FATHER'S NAME FIRST Mihran MIDDLE Palamoudian LAST Palamoudian				15. MOTHER'S MAIDEN NAME FIRST Mghsavidikian MIDDLE Mghsavidikian LAST Mghsavidikian							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unk.		16b. SOCIAL SECURITY NO. unk.		17. INFORMANT Hratch Abrahamian		ADDRESS 3823 Calvert St. N.W. Wash, D.C. 20007					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Ventricular Tachycardia DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarct 10 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION 12/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 							
22a. I certify that (I) (this hospital) attended the deceased from 12/13 19 82 , to 12/13 19 82 , that (I) (we) last saw the deceased alive on 12/12 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Carol Bender DEGREE 				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1982 Dec. 13, 1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carol Bender				22e. ADDRESS 11510 Old Georgetown Rd. Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 18, 1982		23c. NAME OF CEMETERY OR CREMATORY Ridgeland Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Waltham, Mass. Catholic					
24. FUNERAL DIRECTOR NAME W.W. Taltavull ADDRESS 4748 Wisc. Ave. N.W. Wash. D.C. 20016				25a. DATE RECEIVED BY FUNERAL HOME DEC 17 1982 25b. SIGNATURE 							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 1 8	
1. STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Frances I Palo			2a. DATE OF DEATH MONTH DAY YEAR December 14, 1982		2b. HOUR 10:13P_M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan 11 1896		6. AGE IN YEARS (LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp., Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manger	12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST unk unk Jillson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna unk unk		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Dorothy J. Jones ADDRESS see 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 4039 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 to 1982 that (I) (we) last saw the deceased alive on above (1/14/82) (did) (did not) view the body after death.					
22b. SIGNATURE David Kessler		DEGREE MD		22c. DATE SIGNED 12/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Kessler MD			22e. ADDRESS 10620 Georgia Ave, Silver Spring, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-18-82	23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION (CITY OR TOWN) Stamford, Fairfield, Co STATE nn
24. FUNERAL DIRECTOR NAME W W Chambers Co, Inc ADDRESS 8655 Georgia Ave. S S			25a. DATE REC'D BY REGISTRAR DEC 21 1982 REGISTRAR'S SIGNATURE John J. Conner		

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RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK (100-157344)
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text block]

[Large block of illegible text, possibly a memorandum or report body]

Very truly yours,
[Illegible Signature]
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the funeral director's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 does not only injury, or other traumatic event, the medical examiner will be notified.

DHMH-16 (50M 1/81)
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 3 2 7 1 9			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZABETH WILLAMINA PANHOLZER				December 3, 1982			
2. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 8, 1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 74	
7. BIRTHPLACE (STATE OR FOREIGN) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Washington Adventist Hospital		12a. USUAL OCCUPATION (IF WORKED FOR WAGE OR SALARY) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Maryland Prince Geo. Greenbelt				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST William A. Pullin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa E. Taverny			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214 32 7648		17. INFORMANT ADDRESS Joseph A. Panholzer Same as #13 (Son)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1890 IMMEDIATE CAUSE (a) Carcinoma of KIDNEY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/30 , 19 82 , to 12/2 , 19 82 , that (I) (we) lost saw the deceased alive on 12/2 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael Bruce				DEGREE MD		22c. DATE SIGNED 12/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kirkland C. Bruce				22e. ADDRESS 1600 Carroll Ave Takoma Park, Md.			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/7/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.				25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE DEC 8 1982			
24b. ADDRESS Hyattsville, Maryland				25b. REGISTRAR'S SIGNATURE John J. Connel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 7 2 0			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
I. DECEASED NAME				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
William Preston Pannell				December 30, 1982			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
Male		White		Oct. 15, 1921		61	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
S.C.		USA				Montgomery County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Clinical Center, Bethesda, Md.		Instrument super visor		Construction	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Luther - Pannell				Bertha - Knecht			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT	
no				249-18-1870		Mrs. Aileen J. Pannell, wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) 1991 Acute Renal Failure				1 week			
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) Widely Metastatic Malignant Tumor			
				primary site unknown			
				(c) DUE TO, OR AS A CONSEQUENCE OF			
				1 year			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that X (this hospital) attended the deceased from November 15, 1982, to December 30, 1982, that X (we) last saw the deceased alive on December 30, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
C. A. Harmon						Dec. 30, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Claude A. Harmon, M.D.				National Institutes of Health Clinical Center, Bethesda, Md. 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		3 Jan 1983		Graceland Cemetery		Greenville S.C.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
Marshall's Funeral Home 4217 9th St NW: Washington, D.C.				JAN 6 1983			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

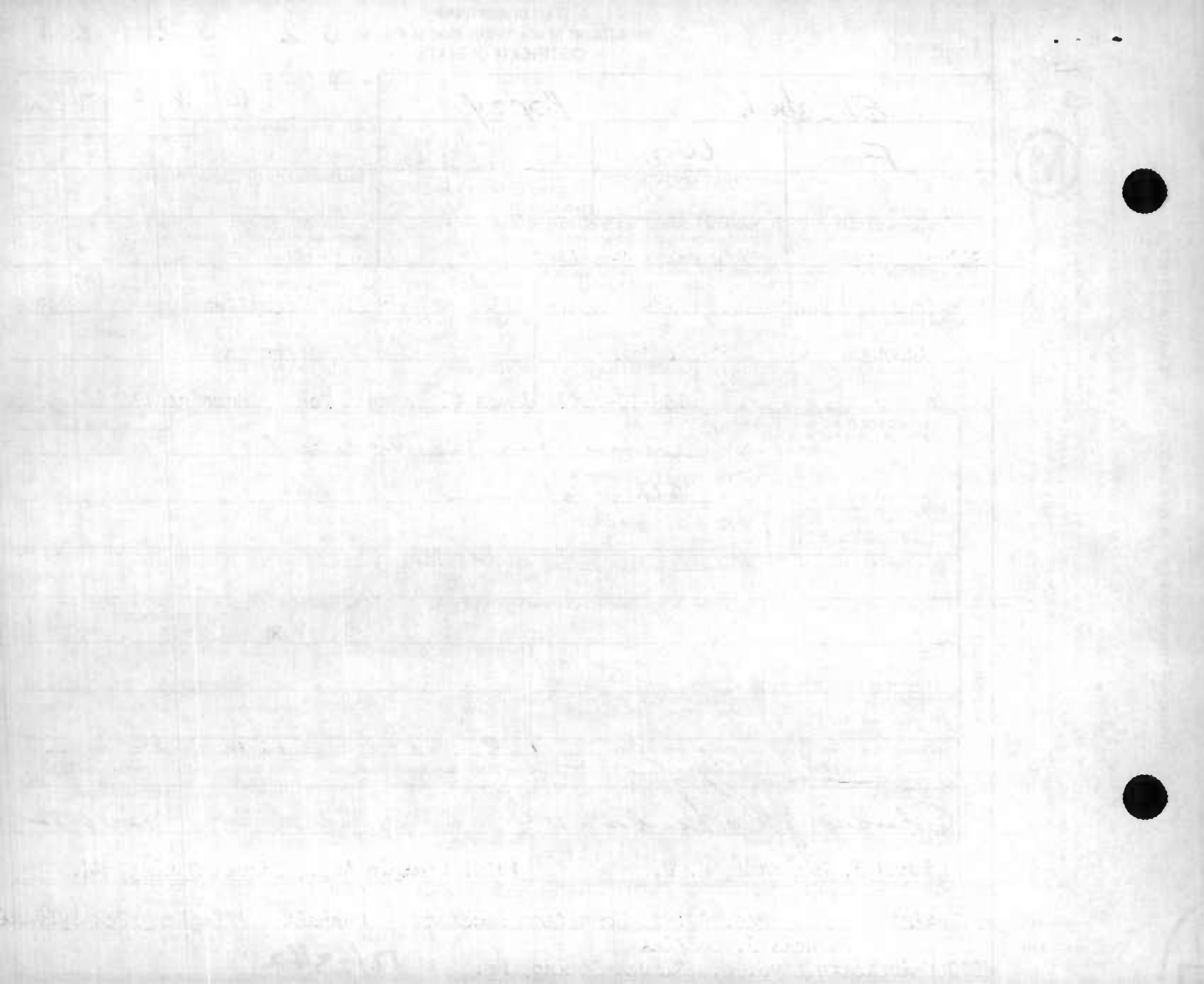
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 7 2 1			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST <i>Elizabeth Popey</i>				MONTH DAY YEAR HOUR <i>12/16/82 7:20am</i>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
<i>Female</i>		<i>White</i>		MONTH DAY YEAR <i>Dec. 1 1894</i>		YRS. MONTHS DAYS HOURS MIN. <i>88</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
<i>Hungary</i>		<i>USA</i>		<i>Montgomery</i>		<i>MD.</i>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<i>Silver Spring</i>		<i>Holy Cross Hospital</i>		<i>Housewife</i>			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
<i>Maryland</i>		<i>Montgomery</i>		<i>Silver Spring</i>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS		13f. APT. NO.	
<i>Unknown Stofan</i>		<i>Unknown</i>		<i>2103 Glenallen Avenue</i>		<i>20906</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
<i>No</i>		<i>166-10-8524</i>		<i>James D. Papay Son</i>		<i>Same as 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12-15</i> , 19 <i>82</i> , to <i>12-16</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>12-15</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Edward J. Richards</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>12-16-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward J. Richards, M. D.</i>				22e. ADDRESS <i>10301 Georgia Ave., Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
<i>Burial</i>		<i>Dec. 20, 1982</i>		<i>Homestead Cemetery</i>		<i>Munhall Allegheny Pennsylvania</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Francis J. Collins</i> <i>500 University Blvd., W. Silver Spring, Md.</i>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				<i>12/23/82</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 2 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Donald W. Parker				2a. DATE OF DEATH MONTH DAY YEAR 12/19/82			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7/30/1919		6. AGE (IN YEARS LAST BIRTHDAY) 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? Amer.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Mont		13c. CITY OR TOWN Silverspring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Parker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Felt		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR RATES) W.W.I.		17. INFORMANT ADDRESS FRANCES N. PARKER - 10 Midhurst Rd. SS MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4920 IMMEDIATE CAUSE (a) Respiratory Failure			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
DUE TO, OR AS A CONSEQUENCE OF (c)				15 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Arteriosclerotic Heart Disease							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/7 , 19 82 , to 12/9 , 19 82 , that (I) (we) last saw the deceased alive on 12/9 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph B. Mizgerd, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH B. MIZGERD, M.D.		22e. ADDRESS 7600 CARROLL AVE. TAKOMA PARK, MD 20912					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE Dec 10, 1982		23c. NAME OF CEMETERY OR CREMATORY Toll Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greenland MD	
24. FUNERAL DIRECTOR NAME ADDRESS Takoma Funeral Home 254 Carroll St NW DC		25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE BEC 13 1982 John J. Connel					

MEDICAL CERTIFICATION



The following is a list of the names of the persons who have been
 named in the report of the Committee on the subject of the
 proposed amendment to the Constitution of the State of New York.
 The names are given in the order in which they were named.
 The names of the persons who have been named in the report of the
 Committee on the subject of the proposed amendment to the
 Constitution of the State of New York are given in the order in
 which they were named. The names of the persons who have been
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Joseph A. Paulus					2a. DATE OF DEATH MONTH DAY YEAR December 11, 1982			2b. HOUR 4:30 P M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 28, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Althea-Woodland of Silver Spring				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Manager		12b. KIND OF BUSINESS OR INDUSTRY A.T. & T.	
13a. STATE Colorado		13b. CITY OR TOWN Denver		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 690 S. Alton Way 80231			
14. FATHER'S NAME FIRST MIDDLE LAST George Paulus		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Smyth		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 528-01-9124		17. INFORMANT ADDRESS John Sherry, Son-in-law, 6209 Verne St. Bethesda, MD. 20817							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR Acc. DEATH</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Days 15 YRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>NONE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> , 19 <u>82</u> , to <u>12/11</u> , 19 <u>82</u> , that (we) last saw the deceased alive on <u>12/11/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Henry W. Stout</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/11/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry W. Stout, M.D.				22e. ADDRESS 10829 Georgia Avenue Silver Spring, Maryland 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 14, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D BY REGISTRAR DEC 17 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u>			

BP

[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side. Includes a large circular stamp on the left and various handwritten notes.]

DEC 17 1965

[Faint handwritten text, possibly "John G. Smith"]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 2 7 2 4							
1. FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH						2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VICTOR NMI PERERA						2a. DATE KNOWN OF DEATH ESTIMATED 12 24 1982						2b. HOUR 11A					
3. SEX M		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 7 21 08		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 12 24 1982		2d. HOUR 4PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cuba				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Chevy Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4515 WILLARD AVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper				12b. KIND OF BUSINESS OR INDUSTRY Electric Company					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE MD						13b. CITY MONTGOMERY		13c. CITY OR TOWN BETHESDA			
14. FATHER'S NAME FIRST MIDDLE LAST Luis Perera						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Francisca Rodriguez						Zip: 20815					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 265-78-0463						17. INFORMANT ADDRESS Dulce M. Perera Wife, Same as item #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) VALVULAR HEART DISEASE 7 YRS DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YRS												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION 1975				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? VALVE IN HEART								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12 24 1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED IN CHAIR									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION CITY OR TOWN STREET STATE 4515 WILLARD AVE BETHESDA MONT MD									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE [Signature]						TITLE (SPECIFY) M.D.						MEDICAL EXAMINER		DATE SIGNED 12/24/82			
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C. MAYLE						ADDRESS 200 Wisconsin Ave Bethesda MD						20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 28, 1982				23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey						25a. DATE REC'D. BY REGISTRAR DEC 29 1982						25b. REGISTRAR'S SIGNATURE [Signature]					
P.A., Bethesda, Maryland																	

208 CALIFORNIA LIBRARY

RECEIVED
JAN 10 1908

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "California" and "Library" are faintly visible.]

DEC 22 1907

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Joseph s.		PERZELLA		PREZELLA		11-2-82		Dec 15		19		12		10		A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE IN YEARS		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	W	April 22		12		70		YRS.		Dec 15		19		12		A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
PENNSYLVANIA		U.S.A.		WIDOWED		DIVORCED		Montgomery		Baltimore		Holy Cross Hosp.		SAFETY ENGINEER		DEPT OF LABOR	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
MD		Montgomery		Sil Spg		YES		41601 Pennis Ave		SAMUEL A. PERZELLA		MARY COSTELLO		NO		207-01-7369	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
DAUGHTER		Acute Myocardial Infarction		4291		DUE TO, OR AS A CONSEQUENCE OF		None		None		None		YES		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
ELLEN DOWD		Chronic Myocardial Disease				DUE TO, OR AS A CONSEQUENCE OF								NO		P.M. 19	
ADDRESS		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		None		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION CITY OR TOWN		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN		COUNTY		STATE	
ROCKVILLE, MD. 20854		None						SILVER SPRING		SILVER SPRING		MONT		MD.			
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN	
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										BURIAL		12/18/82		GATE OF HEAVEN		SILVER SPRING	
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOHN S. ROGERS		1919 SEMINARY RD., SILVER SPRING, MD.						Dec 15/1982		FRANCIS J. COLLINS		DEC 27 1982		John J. Conner			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS								500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							



DEC 3 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 2 6

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Celeste Marie Peters			2a DATE OF DEATH MONTH DAY YEAR 12 / 13 / 82		2b HOUR 9:58 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 23 1922	6 AGE (IN YEARS LAST BIRTHDAY) 60	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash.D.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary Dept.		12b KIND OF BUSINESS OR INDUSTRY of Agr.
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY Mont.	13c CITY OR TOWN S.S.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Lester F. Moss		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Kendig			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None		16b SOCIAL SECURITY NO. 266 38 0066	17 INFORMANT ADDRESS Charleste M. Vines (Daughter) Same as above		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

1599

IMMEDIATE CAUSE (a) **Carcinomatosis**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c) **CARCINOMA GASTRO INTESTINAL TRACT**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6-8 weeks

Months

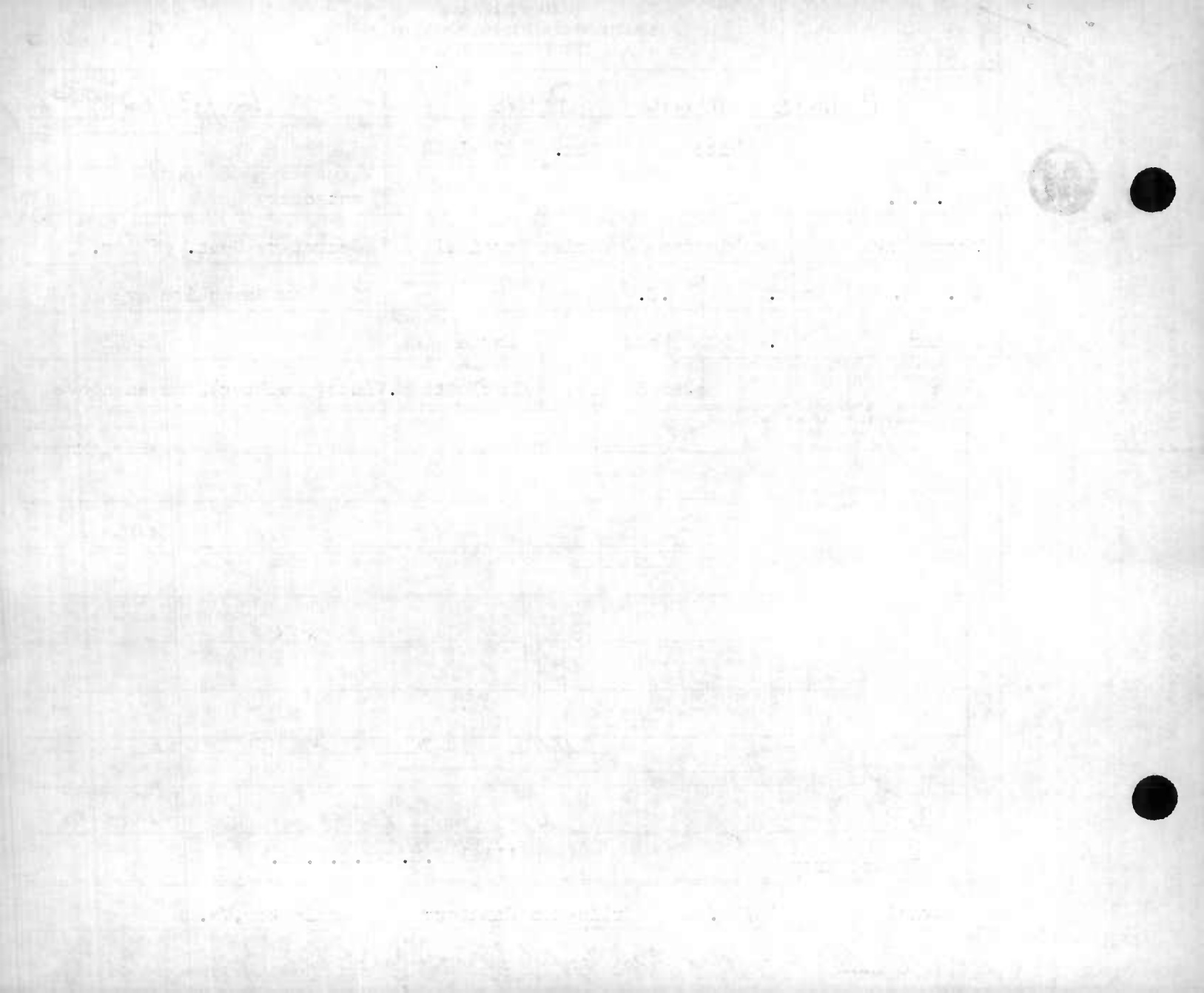
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 1978 , to Dec 13 1982 , that (I) (we) lost saw the deceased alive on Dec 13 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Robert Irey	DEGREE MD	22c. DATE SIGNED 12-13-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Irey	22e. ADDRESS 11161 N.H.Ave.S.S.Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/16/82	23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.
24. FUNERAL DIRECTOR NAME ADDRESS H. H. 11800 New Hampshire Ave		25a. DATE REC'D. BY REGISTRAR DEC 16 1982	25b. REGISTRAR'S SIGNATURE John J. Connelley

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 3 2 7 2 7 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST James Walton Pettitt		2a. DATE OF DEATH MONTH DAY YEAR 12 31 82	
2. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9 24 29	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON	
14. FATHER'S NAME FIRST MIDDLE LAST FREDRICK JACKSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA LEE FURR		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE PAINTER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-34-6486		17. INFORMANT SISTER ADDRESS 7502 PARKWOOD COURT MARY THOMPSON, FALLS CHURCH, VIRGINIA 22042	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY FAILURE</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from <u>12/30</u> , 19 <u>82</u> , to <u>12/31</u> , 19 <u>82</u> , that (ii) (we) last saw the deceased alive on <u>12/31</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Mohar</u>		DEGREE		22c. DATE SIGNED 12/31/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. S. MOHAN MD		22e. ADDRESS 6492 Cardove Rd Lanham MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/4/83		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL	
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRI GEO MD.		25a. DATE REC'D. BY REGISTRAR JAN 10 1983	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 2 8			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JACK E. PHILLIPS, Sr.				2a. DATE OF DEATH MONTH DAY YEAR 12 29 82 2b. HOUR 11 ⁴⁰ _{AM}			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 23 10		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Electronics	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 20782 13b. COUNTY Prince Geo. 13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5812 33rd Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Columbus Phillips		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elinor Adams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 522 05 5625 17. INFORMANT Jack T. Phillips 1727 White Oak Avenue Baltimore, Md. 21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3989 IMMEDIATE CAUSE (a) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Severe Rheumatic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Yes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE PERIOD OF INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Pt fractured nose in fall 10 days before death		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) this hospital attended the deceased from 28 Dec 1982 to 29 Dec 82 , that (2) (we) last saw the deceased alive on 28 Dec 1982 , and that (in my/our) opinion death occurred on the date and hour and from the causes stated above. (If we/they did not) view the body after death.			
22b. SIGNATURE Alan I. Kermaier, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 29 Dec 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN I. KERMAIER, MD		22e. ADDRESS 9801 GEORGETT AVE S.S. MD 20902					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/31/82		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem		23d. LOCATION Hyattsville P.G. Maryland	
24. FUNERAL DIRECTOR'S NAME Francis Gasch's Sons Funeral Home, P.A. ADDRESS Hyattsville, Maryland				25a. DATE RECD. BY REGISTRAR JAN 5 1983 25b. REGISTRAR'S SIGNATURE John J. Connelley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 82 32729					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE R. PICKERAL					12/ 27 /82					
3 SEX male		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR FEB 14, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7b. HOUR 8.23 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLUMBER		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED			
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2614 ELMONT STREET 20906	
14. FATHER'S NAME FIRST MIDDLE LAST RUBEN PICKERAL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN BRYANT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> YES			16b. SOCIAL SECURITY NO. WW II		17. INFORMANT DOROTHY L. PICKERAL		ADDRESS SAME AS 13 WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic Shock 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Myocardial Infarction (c) Coronary Artery Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-7 hours 8-10 hours										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 12/27 , 19 82 , to 12/17 , 19 82 , that (1) (we) last saw the deceased above (1) (we) (did) not see the body after death.										
22b. SIGNATURE Herman B Segal			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/27/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herman B Segal			22e. ADDRESS 5832 Shields Drive Bethesda Md 20816							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/30/82		23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS		23d. LOCATION CITY OR TOWN COUNTY STATE CHELLENHAM PRI GEO MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS					25a. DATE REC'D BY REGISTRAR DEC 29 1982					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					25b. REGISTRAR'S SIGNATURE Joan J. Connel					

MEDICAL CERTIFICATION

1. Name of the plant
2. Name of the collector
3. Locality
4. Date of collection
5. Number of specimens
6. Name of the collector
7. Locality
8. Date of collection
9. Number of specimens
10. Name of the collector
11. Locality
12. Date of collection
13. Number of specimens

14. Name of the collector
15. Locality
16. Date of collection
17. Number of specimens
18. Name of the collector
19. Locality
20. Date of collection
21. Number of specimens

22. Name of the collector
23. Locality
24. Date of collection
25. Number of specimens
26. Name of the collector
27. Locality
28. Date of collection
29. Number of specimens

30. Name of the collector
31. Locality
32. Date of collection
33. Number of specimens
34. Name of the collector
35. Locality
36. Date of collection
37. Number of specimens

38. Name of the collector
39. Locality
40. Date of collection
41. Number of specimens
42. Name of the collector
43. Locality
44. Date of collection
45. Number of specimens

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the deceased, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

For page 3 after death

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 3 0			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARL PITLER				2a. DATE OF DEATH MONTH DAY YEAR 12-18-82		2b. HOUR 2 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 5, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant		12b. KIND OF BUSINESS OR INDUSTRY Liquor	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Chaim Pitler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Singer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-12-7456		17. INFORMANT Larry Pitler 1500 Woodman Avenue Silver Spring, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST 4149 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC MYOGENIC DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1913							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: HYPERTENSION, SICK SINUS SYNDROME.							
19a. DATE OF OPERATION 12/10/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SICK SINUS SYNDROME PERMANENT PACEMAKER		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:15 12/18/82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1115		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12118 82			
22a. I certify that (I) (this hospital) attended the deceased from 12/11/82 to 12/18/82 , that (I) (we) lost saw the deceased alive on 12/18/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN Donald Goldenberg MD				22c. DATE 12/18/82		22d. ADDRESS 20902 SILVER SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 12/19/1982		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden Falls Church, Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE 20902 SILVER SPRING, MARYLAND	
24. FUNERAL DIRECTOR NAME Donald M. Stein				24b. ADDRESS 232 Carroll Street, N. W. Washington, D. C.		24c. DATE REC'D. BY REGISTRAR DEC 23 1982	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at a

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 3 2 7 3 1			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (FIRST, MIDDLE, LAST) Cornelia Esther Pofahl				2a. DATE OF DEATH MONTH DAY YEAR 12/26/82			
3. SEX Female				2b. HOUR 2:00 P.M.			
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 05 - 14 09		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Montgomery			
13c. CITY OR TOWN Germantown				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 18626 Turmeric CT.							
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence nmn Kennedy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANITA nmn Davis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 549-01-0160			
17. INFORMANT Johnneen P. Eckart							
18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4920 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Emphysema 20 years DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET				21g. CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/26/82 to 12/26/82, that (I) (we) last saw the deceased alive on 12/26/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death.)							
22b. SIGNATURE OF PHYSICIAN Robert C. Macon M.D.				22c. DATE SIGNED 12/26/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Macon				22e. ADDRESS 809 Viars Mill Rd. Rockville, Md 20851			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 12-17-1982			
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Suitland				23d. LOCATION CITY OR TOWN COUNTY STATE Pr. Geo. Maryland			
24. FUNERAL DIRECTOR NAME W. W. Chambers Co, 8655 Georgia Ave. Sil. Spg				25a. DATE REC'D. BY REGISTRAR DEC 30 1982			
25b. REGISTRAR'S SIGNATURE John J. Conner							

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 3 2 7 3 2	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) <i>Sylvia T. Politz</i>										2a. DATE KNOWN OF DEATH <i>Dec 21 1982</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>10-27-1916</i>		6. AGE (IN YEARS) <i>66</i> YRS.		7c. DATE PRONOUNCED DEAD <i>Dec 20 1982</i>		2b. DATE KNOWN OF DEATH <i>Dec 21 1982</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WASH. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD</i>					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holtz Cross Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SUPERVISOR</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. GOVT.</i>					
13a. STATE <i>MD</i>		13b. CITY OR TOWN <i>Silver Spring</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <i>607 Lowmiller Lane</i>					
14. FATHER'S NAME FIRST <i>LOUIS</i> MIDDLE <i>---</i> LAST <i>ROSENBERG</i>		15. MOTHER'S MAIDEN NAME FIRST <i>MARY</i> MIDDLE <i>---</i> LAST <i>HEIN</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>-----</i>		16b. SOCIAL SECURITY NO. <i>578-03-8873</i>		17. INFORMANT <i>MR. PERCY POLITZ SILVER SPRING, MD.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4291 Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>---</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>											
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>John J. Danzansky</i>		TITLE (SPECIFY) <i>Dep.</i>		MEDICAL EXAMINER		DATE SIGNED <i>Dec 20/1982</i>					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>12-22-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>KING DAVID MEM GDN.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>FALLS CHURCH, VA.</i>					
24. FUNERAL DIRECTOR <i>1170 ROCKVILLE PK. ROCKVILLE MD. DANZANSKY-GOLDBERG MEM CHP, INC.</i>						25a. DATE REC'D. BY REGISTRAR <i>DEC 28 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Danzansky</i>			

RECEIVED



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 3 3

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Betty M. Powers			2a DATE OF DEATH MONTH DAY YEAR December 21, 1982			2b HOUR 3:15PM M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 13 41		6 AGE (IN YEARS LAST BIRTHDAY) 41 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Mt. Airy		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph William Lewis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Elizabeth Slider		13e STREET ADDRESS 13138 Manor Drive			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 195-32-2734		17. INFORMANT ADDRESS Blaine Powers, Item 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 ^h 142.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Coronary heart failure 2° arteriosclerotic cardiomyopathy. Diabetes mellitus, smoker's</i>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from _____, 19 <u>73</u> to <u>21 Dec</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>21 Dec</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Donald E. Diello MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 21 Dec 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Donald E. Diello M.D.</i>				22e. ADDRESS <i>1811 Prince Ph. 1st 220 Frederick Road, #202 Olney, Md 20832 Gaithersburg, Maryland 20877</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 24, 1982		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Maryland	
24. FUNERAL DIRECTOR NAME Clin L. Molesworth, P.A., Damascus, Md.				25a. DATE REC'D. BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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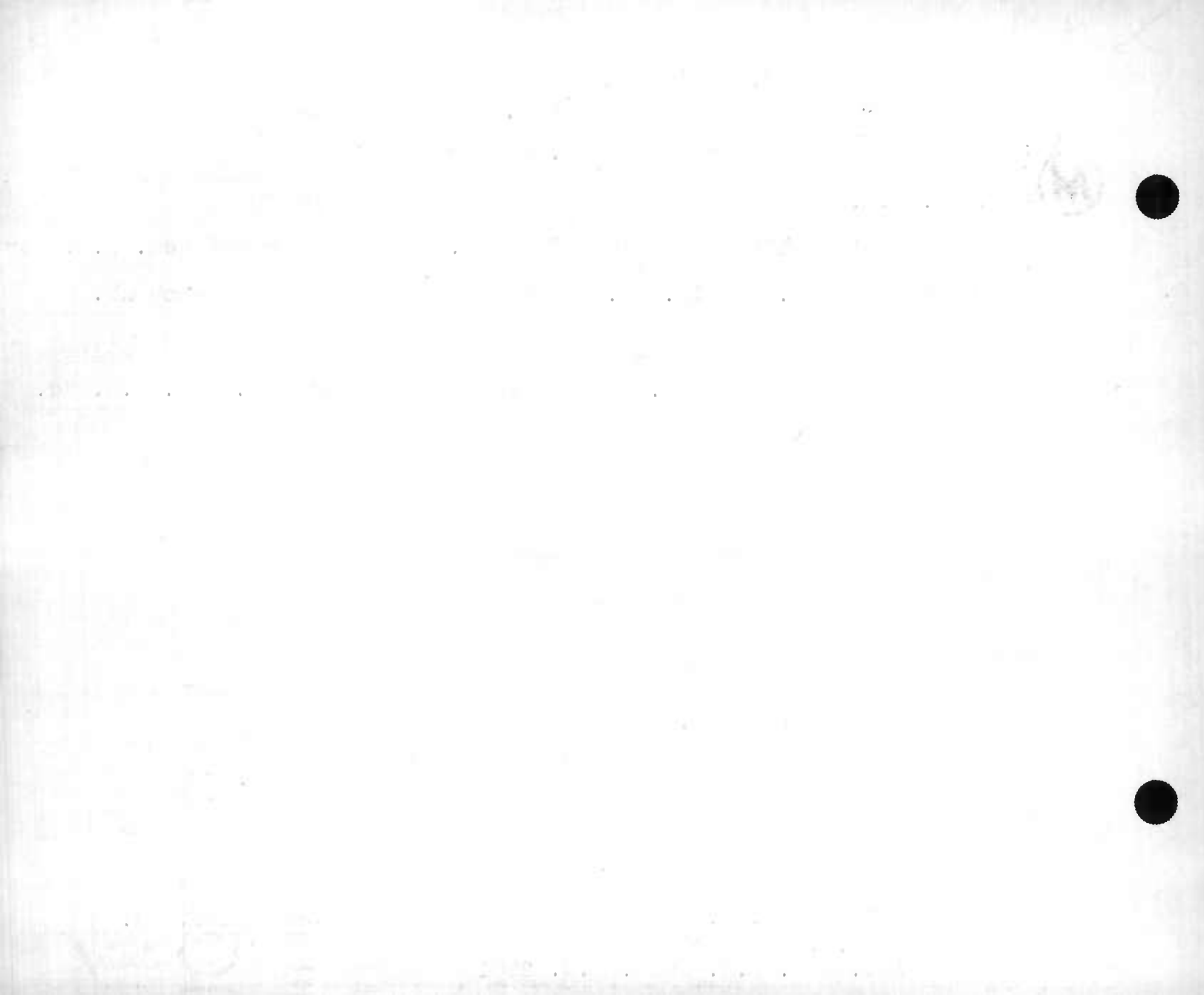
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "yes" (i.e., any injury, or other traumatic event, the medical examiner must be notified).

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 3 4 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) Anna C. Preinkert				2b. HOUR 2:30 PM			
3 SEX female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 17220 New Hampshire Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker and		12b. KIND OF BUSINESS OR INDUSTRY Ret. U.S. Gov.	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Mont. Sil. Sp.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8627 Piney Branch Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST John Bauer				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Eller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO unk.		17 INFORMANT ADDRESS Theresa Burke 10110 Ga. Ave. S.S. Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MALNUTRITION + CACHEXIA 1490 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA THROAT + NECK 2-3 months							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN. 19 82 to Dec 5, 19 82, that (I) (we) last saw the deceased alive on 30 October 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if true) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] DEGREE DR. EINO MAGI				22c. DATE SIGNED 12-5-82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B. IREY	
22e. ADDRESS 11161 New Hampshire Ave, Silver Spring, Md				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 8, 1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Md.	
24 FUNERAL DIRECTOR W.W. Taltavull				25a. DATE REC'D. BY REGISTRAR DEC 9 1982			
25b. REGISTRAR'S SIGNATURE [Signature]				25c. REGISTRAR'S SIGNATURE [Signature]			



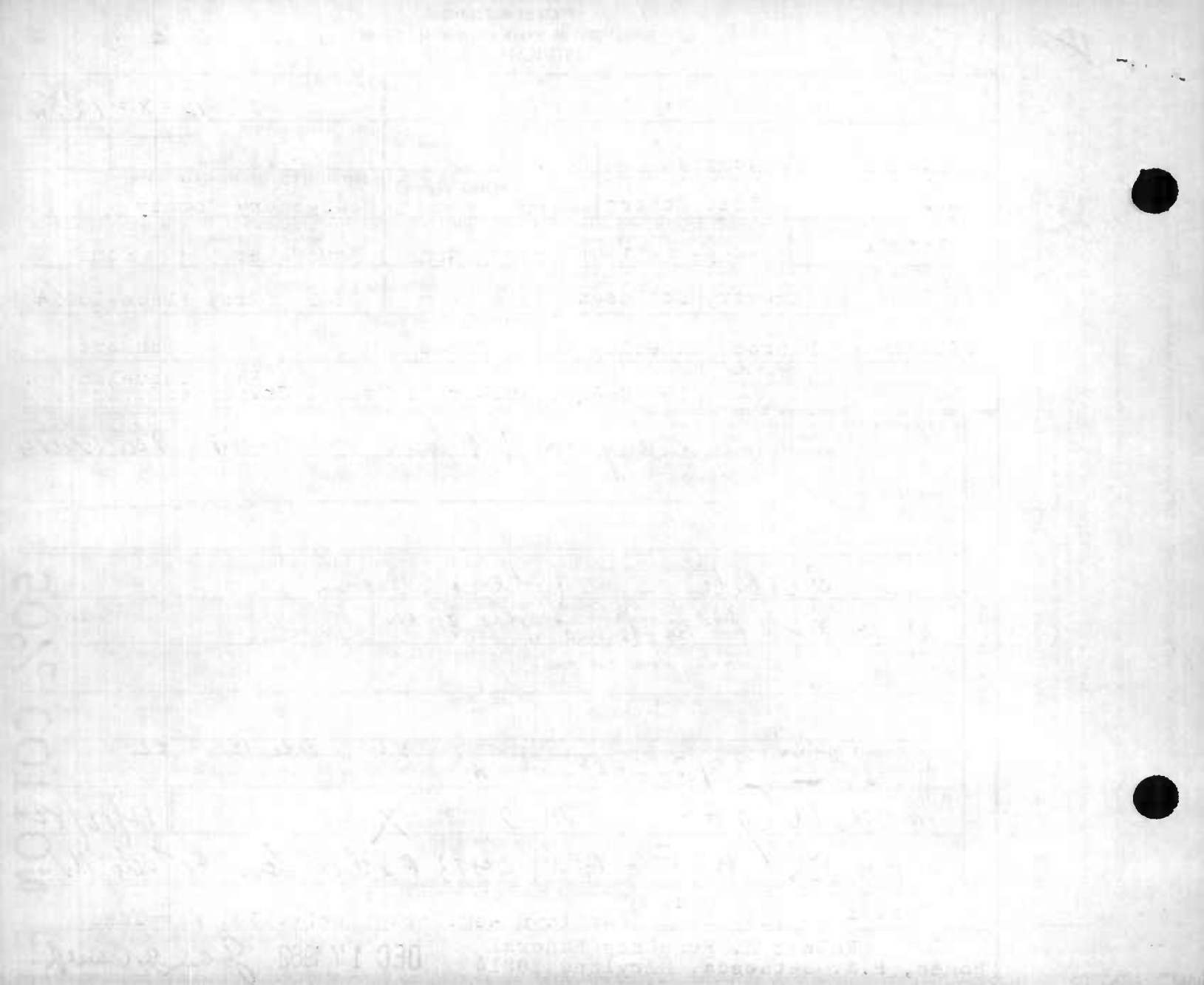
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 3 5 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) RUTH C. PRESS				2a. DATE OF DEATH MONTH DAY YEAR 12-12-82 2b. HOUR 12:30 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 27, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST William Monroe Mierley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Benkert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-48-4206		17. INFORMANT ADDRESS 1441 Chevelle Dr. Richmond, Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) Gangrene Left Lower Extremity APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two Weeks DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Diabetes - Arteriosclerosis							
19a. DATE OF OPERATION 10 14 82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Left Renal - Cerebral Hypertension		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the funeral director) attended the deceased from Nov 12/7 , 19 82 , to Dec 12 , 19 82 , that (I) (we) last saw the deceased alive on 12/7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James W. Egan		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES W. EGAN		22e. ADDRESS 5413 Cedar Lane Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 15, 1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR DEC 17 1982		25b. REGISTRAR'S SIGNATURE John J. Gough	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) MINNIE L. PRICE					2a. DATE OF DEATH MONTH: Dec. DAY: 14 YEAR: 1982 2b. HOUR: 0448 M					
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH: Apr. DAY: 7 YEAR: 1891		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN: 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST: Jacob MIDDLE: Enoch LAST: Myron Williams					15. MOTHER'S MAIDEN NAME FIRST: Mary MIDDLE: Frances LAST: Rickabaugh					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 510 22 7696		17. INFORMANT ADDRESS: Hope R. Stewart see # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 20 years 20 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Sept. 19 77 , to Dec 14 19 82 , that (I) (we) last saw the deceased alive on Dec 13 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE James R. Moore Jr. MD				DEGREE MD				22c. DATE SIGNED 12-14-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Moore Jr. MD				22e. ADDRESS 207 Brookes Ave Gaithersburg Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit		23b. DATE Dec. 15, 1982		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Kansas City Kansas				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				ADDRESS Funeral Homes Rockville, Maryland		25a. DATE REC'D BY REGISTRAR DEC 20 1982		25b. REGISTRAR'S SIGNATURE John J. Conner		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 3 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Chauncey D Pugh				2a. DATE OF DEATH MONTH DAY YEAR Dec 29 1982				2b. HOUR 8:36 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 23 1901		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 MRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY U.S. POST OFF.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1223 Arcola Avenue 20902			
14. FATHER'S NAME FIRST MIDDLE LAST John Pugh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Haas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 1922-1929 216-44-9511		17. INFORMANT ADDRESS Frances J. Pugh Wife Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MIN 1 MO	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) viewed attended the deceased from OCT 29 Dec 82 to 29 Dec 82 that (I) was saw the deceased alive on above, (I) was did not view the body after death. and that in (my) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE Walter E. Gooch MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 30 Dec 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOCH MD						22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 3, 1983		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.			
24. FUNERAL DIRECTOR NAME Francis J. Collins						24a. DATE REC'D. BY REGISTRAR JAN 6 1983		24b. REGISTRAR'S SIGNATURE John J. Conner			
500 University Blvd., W. Silver Spring, Md.											

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1 - FOR STATE REGISTRAR										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR
BABY BOY RAMIREZ					DEC. 24, 1982					5:54am
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
MALE		HISPANIC		DEC. 24, 1982				MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND		U.S.				MONTGOMERY		MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK		WASHINGTON ADVENTIST HOSPITAL				N/A		N/A		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
MD		MONT.		S.S.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		932 WAYNE AVENUE #101		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
JOSE DELORES HERNANDEZ		ZORAIDA		CRUZ						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NO		N/A		MOTHER'S MEDICAL CHART						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Extreme immaturity.										
7650										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Multiple congenital abnormalities										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
N/A		N/A				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR		N/A						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		N/A		N/A						
22a. I certify that (I) (this hospital) attended the deceased from December 24, 1982, to December 24, 1982, that (I) (we) lost saw the deceased alive on December 24, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
V.S. Vinayakom. MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
V.S. VINAYAKOM: 7600 CARROLL AVENUE TAKOMA PARK, MARYLAND 20912										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		
CREMATION				WASHINGTON ADVENTIST HOSPITAL Takoma Park:Mont.:MD		CITY OR TOWN		REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR				
		HERBERT Z. SHIROMA		7600 CARROLL AVE. T.P. MD		JAN 12 1983 John J. Connel				

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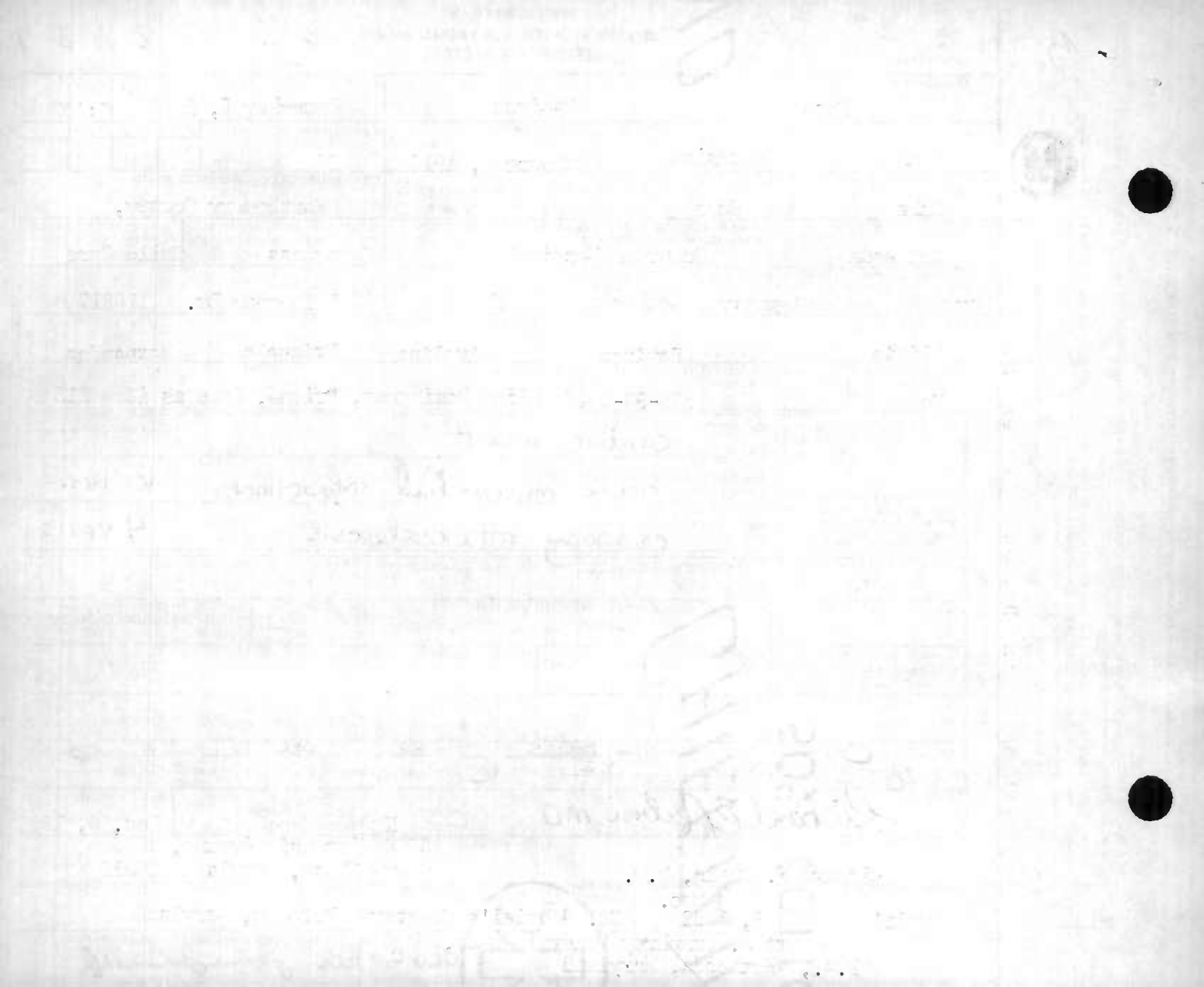
IMPORTANT: If item 21 is marked as item 19, shows any injury, or other traumatic event, the medical examiner must be notified at once.

RELEASED BY: Dr. John Tauber, M.D.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 7 3 9 REG. NO.			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) Rosa Ramirez					2a. DATE OF DEATH MONTH DAY YEAR December 5, 1982					2b. HOUR 5:40P M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 9, 1916			6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cuba		7b. CITIZEN OF WHAT COUNTRY? Cuba		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.						
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Governess		12b. KIND OF BUSINESS OR INDUSTRY Child Care				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 8201 Thoreau Dr. 20817				
14. FATHER'S NAME FIRST MIDDLE LAST Eligio Ramirez					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Avelina Vrizuela Hernandez								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 579-90-2025		17. INFORMANT Elina Dominguez, Friend, Same as item #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary atherosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs. 4 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <u>DEC 5</u> , 19 <u>82</u> , to <u>DEC 5</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>DEC 5</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Richard E. Rubin M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED Dec. 6, 1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Rubin, M.D.					22e. ADDRESS 5530 Wisconsin Avenue, #805 Chevy Chase, Maryland 20815								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 8, 1982		23c. NAME OF CEMETERY OR CREMATORY St. Gabriel's Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Potomac, Maryland					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland					25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 8 - 1982 <u>John J. Conner</u>								

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

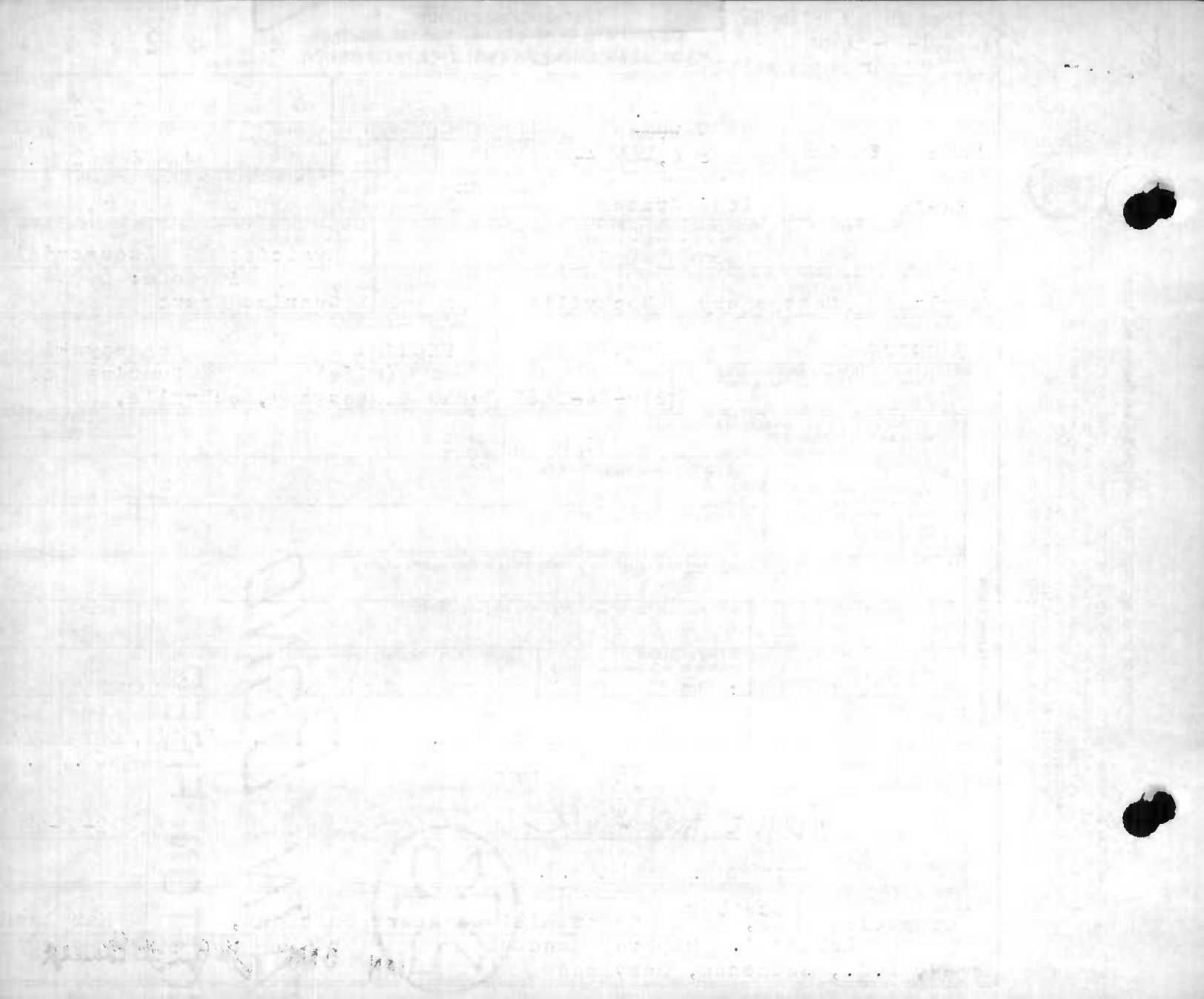
Item #5 & 6 Film G575

FOR 1-13-83 gw
STATE REGISTRAR per phone call

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Srinivasa R. Rangaswamy								12 29 1982								M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE IN YEARS		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male		Indian		August 4, 1934		48 YRS.		MONTHS		DAYS		HOURS		12		29		1982		9:19 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
India		United States				Montgomery County, MD.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Bethesda		Suburban Hospital		Physicist		Industrial															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		Zip Code: 20854											
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2 Sunrise Court													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife)		ADDRESS											
UNKNOWN		UNKNOWN		No		219-64-2669		Radha Rangaswamy, Rockville, MD		2 Sunrise Ct.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Multiple Injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 4 1 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			
Ricardo T. Rankin				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
12-13-82 7:45 PM							
3. SEX Male		4. RACE Latin		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.	
Sept. 26, 1907		75					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
So. America		Columbia		Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Washington Adventist Hospital		Clergy		S.D.A.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				13e. STREET ADDRESS			
Maryland Prin. Geo's Hyattsville				2218 Charleston Place			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Rankin				Anna Newball			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		NONE		Loida Garcia (Daughter) (Same as # 13 above)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1919 Brain tumor (Glidelestroma) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Nov. 19/82		Cran. of tumor for biopsy					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
		19					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 11, 1982, to Dec. 13, 1982, that (I) (we) lost the deceased on Dec. 13, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Baltazar E Perez		MD				Dec. 14/82	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
BALTAZAR E PEREZ		10620 Genga Ave. Sil. Springs, Md. - 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		12/20/1982		Ft. Lincoln Cremat'y		Brentwood, P.G., Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY AN ATTENDING PHYSICIAN, REGISTRAR, SIGNATURE			
Arthur Walters		Wash. DC		DEC 17 1982			

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MEDICAL CERTIFICATION

1. DECEASED NAME		2a. DATE OF DEATH		2b. HOUR	
TYPE OR PRINT	FIRST MIDDLE LAST	MONTH DAY YEAR	MONTH DAY YEAR	MONTH DAY YEAR	MONTH DAY YEAR
FRANK C. RAUSCH		Dec 26, 1982		2:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE	
Male	White	10-19-93		89 88 YRS.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Illinois	U.S.A.			Montgomery County MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital		Retired		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
Maryland		Montgomery	Silver Spring	1712 Alberti Dr.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Frank		Marie		UNKNOWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		W.W. I 318-10-6945		3652 Gunston Rd. Alexandria, VA. 22302	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 4273 PNEUMONIA, General					3 days
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure					7 days
DUE TO, OR AS A CONSEQUENCE OF (c) Atrial Fibrillation					5 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic Cardiovascular Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 12-24-82 to Dec 26, 1982, that (I) (we) last saw the deceased alive on Dec 26, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
George B. Patrick JMD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12-26-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
George B. Patrick JMD		9221 Colesville Road Silver Spring, Md 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Removal		12-26-82	Geo. Wash. Med. School		Washington, D.C.
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Columbia Mortuary Services		225 Missouri Ave. Washington, D.C.		John J. Smith	

BP



Illinois U.S.A. Montgomery County

River Spring Holy Cross Hospital National

Maryland Montgomery River Spring

Frank Denny Mexico

Yes W.V. I 318-10-6000 Gloria Shulton Alexandria, Va. 22302

1962 Gunston St.

1962 Gunston St.

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1962 Gunston St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 7 4 3		
1. FOR STATE REGISTRAR		REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) CLAUDE ELMER RINGER						2a. DATE OF DEATH MONTH DAY YEAR 12-06-82			2b. HOUR 11:25 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec 12 1902		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 2 YEARS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipping Clerk			12b. KIND OF BUSINESS OR INDUSTRY Film			
13a. STATE Md.				13b. COUNTY PG		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4501 Usange Street		
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Ringer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Blanche Donaldson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 578-10-8746		16c. INFORMANT Anna Schaut, Daughter			16d. ADDRESS 4501 Usange St., Beltsville, Md. 20705			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) METASTATIC CARCINOMATOSIS FROM CARCINOMA COLON DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 11-10-1982 to 12-6-1982 , that (I) (we) lost saw the deceased alive on 12-6-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE T. Mohi-Din						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHULAM MOHI-UD-DIN						22e. ADDRESS 3400 University Blvd, East Adelphi M.D. 20783						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-9-82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G., Maryland				
24. FUNERAL DIRECTOR NAME Robt E Wilhelm						ADDRESS 4308 Suitland Rd., Suitland, Md.		25. DATE REC'D BY REGISTRAR DEC 13 1982				

2/10/68 Black River



[Faint, mostly illegible handwritten text follows, appearing to be a list or series of notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, then a medical examiner must be called to examine the body.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 3 2 7 4 4				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST Evelyn Rose Rackner					MONTH DAY YEAR 12-19-82				
3. SEX					2b. HOUR				
Female					1:05 am				
4. RACE					5. DATE OF BIRTH				
Caucasian					MONTH DAY YEAR 6-11-1934				
6. AGE (IN YEARS LAST BIRTHDAY)					7. BALTIMORE CITY OR COUNTY OF DEATH				
48 YRS.					Montgomery MD.				
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia					Montgomery MD.				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				
Takoma Park					Washington Adventist				
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
13a. STATE					13b. KIND OF BUSINESS OR INDUSTRY				
Md.					Home maker				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Clarence W. Williams					FIRST MIDDLE LAST Kate Maitland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.				
No					223-38-0085				
17. INFORMANT					ADDRESS				
Jane Taylor Same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I: DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST									
1809									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) CARCINOMA Cervix with metastasis									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Exhaustion; Renal insufficiency; Right sided pneumothorax									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (I) (this hospital) attended the deceased from 12-2-82, 1982, to 12-19-1982, that (I) (we) last saw the deceased alive on 12-18-1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE									
22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
22e. ADDRESS									
22f. DATE REC'D. BY REGISTRAR									
22g. REGISTRAR'S SIGNATURE									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
23b. DATE									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION CITY OR TOWN COUNTY STATE									
23e. DATE REC'D. BY REGISTRAR									
23f. REGISTRAR'S SIGNATURE									
24. FUNERAL DIRECTOR NAME									
24a. ADDRESS									
24b. DATE REC'D. BY REGISTRAR									
24c. REGISTRAR'S SIGNATURE									

A.2.

T. L. Brown, Jr., Editor

200 29

2000 1 1 1

Chapman

FD-302 (Rev. 1-25-60)

10-11-59 52-55-51 1-1-58

1800-1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. STATE REGISTRAR		REG. NO. 8 2 3 2 7 4 5							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY MCKENZIE ROPER						2a. DATE OF DEATH MONTH DAY YEAR DEC. 19 82		2b. HOUR 1953 P_M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 30 1901		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NHBETHESDA, MD., 20814				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. ARMY		12b. KIND OF BUSINESS OR INDUSTRY GOVT.	
13a. STATE MD. 20817				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL CALHOUN ROPER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOU nnn MCKENZIE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1923-55 677 52 5374		17. INFORMANT ADDRESS HARRY MCKENZIE ROPER, JR., LORTON, VA., 22079			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 POSTEROSEPTAL MYOCARDIAL INFARCT IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 19 1982 , to DECEMBER 19 1982 , that (I) (we) last saw the deceased alive on DECEMBER 19 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 20 DEC 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. TURK, LCDR, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/23/82		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.				25a. DATE REC'D. BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

[illegible]

Items 13a-e per phone 12/30/82

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 1 4 6

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE FIRST MIDDLE LAST ROUNDTREE			2a. DATE OF DEATH MONTH DAY YEAR 12-20-82		2b. HOUR 12:45PM	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 11-24-00		
6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ELVAN MANOR HEALTH CARE Ctr LAUNDRESS		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.		12b. KIND OF BUSINESS OR INDUSTRY		13b. STREET ADDRESS St. Elizabeth's Hospital		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Love		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Millie Sneed		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No		
17. SOCIAL SECURITY NO. 578-09-7902		18. INFORMANT Mrs. Dorothy Bush/sister, 1505 Benning Rd. N.E.		19. ADDRESS		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardiovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Divorce APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		22a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21h. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 12/20/82 to 12/20/82, that (1) (we) lost saw the deceased on 12/20/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Barry N. Rosenbaum, M.D.		DEGREE M.D.		22c. DATE SIGNED 12/20/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY N. ROSENBAUM		22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20895		22f. REGISTRAR'S SIGNATURE John G. Canine		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-82		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		
23d. LOCATION CITY OR TOWN Landover, Md.		23e. DATE REC'D. BY REGISTRAR DEC 28 1982		23f. REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR NAME ADDRESS John T. Rhines Co., 3015 12th St. N.E., D.C. 20001						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



WYOMING

CO.

WYOMING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 4 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Thelma Duane Royal</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>Dec. 17, 1982</i>		2b. HOUR <i>5 53 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb 5 1933</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>49</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>D. C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Mont Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerical</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>D. C.</i>		13b. COUNTY <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1802 Irving Street, N.W.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Nichols</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Peggy Misenheimer</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>577-44-9428</i>		17. INFORMANT ADDRESS <i>Ms. Janet D. Royal/daughter/709 Kaplan Court Landover, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>1749 ACUTE RENAL FAILURE</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 DAYS</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARCINOMA OF BREAST</i>						<i>3 YEARS</i>	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <i>11/28/82</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>INTESTINAL OBSTRUCTION</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 79</i> , to <i>Dec 17 1982</i> , that (I) (we) lost saw the deceased alive on <i>Dec 16 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Alfred Morgan</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/17/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALFRED MORGAN</i>				22e. ADDRESS <i>4200 WISCONSIN AVE NW WASHINGTON 20016</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-21-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Memorial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landover, Md.</i>	
24. FUNERAL DIRECTOR NAME <i>John T. Rhines Co., 3015 12th St., N.E.D.C. 20017</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 27 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

BP

NOT FOR COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's certificate must be obtained.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 3 2 1 9 AM									
1- FOR STATE REGISTRAR					REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACOB J SACHS					2a. DATE OF DEATH MONTH DAY YEAR 12/5/82					2b. HOUR 11:05 AM				
1. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 15 98			6. AGE (IN YEARS LAST BIRTHDAY) MONTH YRS. 84			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PRWA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY Building				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN Maryland Monig Kensington					13e. STREET ADDRESS 10920 Conn Ave					13f. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST ISSAC nmv Sachs					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA nmv Schein					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None				
16b. SOCIAL SECURITY NO. 148-01-3959					17. INFORMANT ADDRESS 10521 IRAMayenson, Middlegate Rd, S.S.					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) 3 days				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute Renal Failure										19a. DATE OF OPERATION				
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) <input checked="" type="checkbox"/> (New hospital) attended the deceased from 12/5/82 , 19____, to 12/5/82 , 19____, that (I) <input checked="" type="checkbox"/> saw the deceased alive on 12/5/82 , 19____, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.										22c. DATE SIGNED 12/6/82				
22b. SIGNATURE Carl I. Schoenberger MD					DEGREE MD					22d. DATE SIGNED 12/6/82				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Carl I. Schoenberger MD					22f. ADDRESS 4701 Randolph Rd Rockville					22g. DATE REC'D. BY REGISTRAR DEC 10 1982				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 12-8-82					23c. NAME OF CEMETERY OR CREMATORY King David Memorial Falls Ch. Fairfax VA				
24. FUNERAL DIRECTOR NAME W.W. Chambers Co					24a. ADDRESS 8605 Georgia Ave					24b. REGISTRAR'S SIGNATURE Joan J. Gainer				

11/11/11 11:11 AM 11/11/11 11:11 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 2 7 4 9

1. DECEASED-NAME (Type or print) First Middle Last Doris Rosenberg Salus			2a. DATE OF DEATH Month Day Year 12 12 1982			2b. HOUR 4:19^{AM}	
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 11, 1931		6. AGE (In years last birthday) 51 YRS.	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9524 Lawnsberry Terr.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Market Research Consultant		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 9524 Lawnsberry Terr.		14. FATHER'S NAME First Middle Last Lester Rosenberg		15. MOTHER'S MAIDEN NAME First Middle Last Irene Rosengerger		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16b. SOCIAL SECURITY NO. 160-26-1039		17. INFORMANT Joseph W. Salus		17. ADDRESS 9524 Lawnsberry Terr. Sil. Spr., Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) 2 years	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 4960		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 82 to 12/3 , 19 82 , that (I) (we) last saw the deceased alive on 12/3 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE Carl I. Schenberger MD		22c. DATE SIGNED 12/13/82		22d. PHYSICIAN'S NAME (Type) Carl I. Schenberger MD		22e. ADDRESS 4701 Randolph Rd. Rockville MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/14/82		23c. NAME OF CEMETERY OR CREMATORY Adath Jeshurun Cemetery		23d. LOCATION (City or Town) (County) (State) Philadelphia, Pa.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a. RECORD BY REGISTRAR John J. Canine		25b. REGISTRAR'S SIGNATURE John J. Canine		25c. DATE DEC 16 1982	

MASSACHUSETTS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF VITAL RECORDS



1914

1914

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

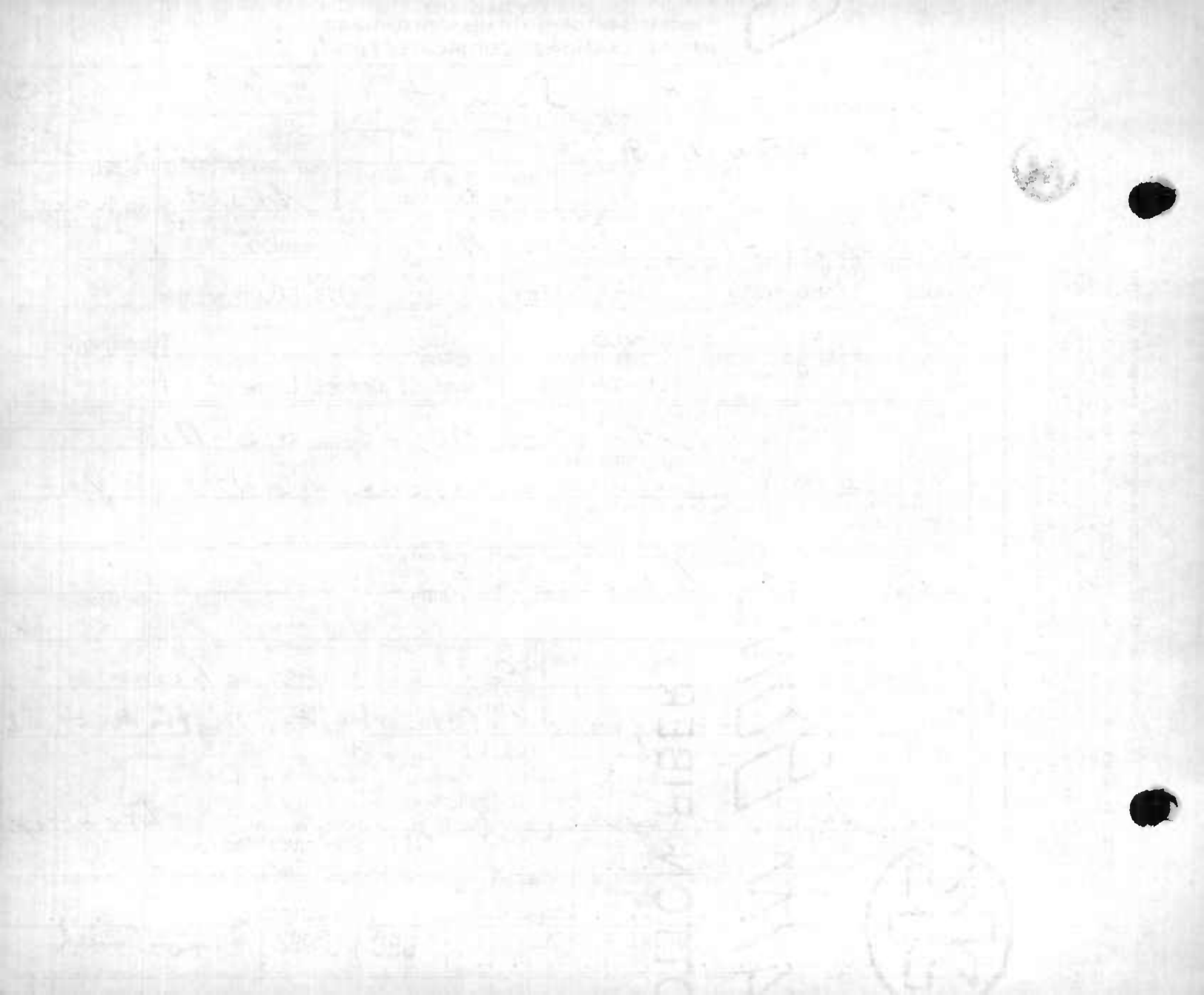
1. DECEASED-NAME (Type or print) SAMEN		Middle E.		Last SAMEN		2a. DATE OF DEATH Month 12 Day 2 Year 82			2b. HOUR 1 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-21-21		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 17060 KING JAMES WAY		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY Mont.		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 17060 KING JAMES WAY			
14. FATHER'S NAME First Michael Middle Samen		15. MOTHER'S MAIDEN NAME First Grace Middle Howell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 578-24-3868		17. INFORMANT Allen E. Thompson		3533 Leesburg Court #204 Alexandria, Va. 22302					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) High BP. DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS-	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 9/10 , 19 79 , to 11/19 , 19 82 , that (I) (we) last saw the deceased alive on 11/10/82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Farwell		DEGREE DR. CHARLES FARWELL		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/3/82					
22d. PHYSICIAN'S NAME (Type) DR. CHARLES FARWELL		22e. ADDRESS 11406 Viers Mill Rd., Wheaton Md. 20902									
23a. BURIAL (CREMATION REMOVAL) (Specify) CREMATION		23b. DATE 12-5-82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION (City or Town) (County) (State) Alexandria, Va.					
24. FUNERAL DIRECTOR Arlington Funeral Home		ADDRESS 3901 N. Fairfax Dr. Arlington, Va. 22203		25a. REC'D BY REGISTRAR DATE DEC 9 1982		25b. REGISTRAR'S SIGNATURE John J. Conner					



CHIEF
POLICE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 7 5 1	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mollie K. Smet										2a. DATE KNOWN OF DEATH ESTIMATED Dec 19 1982	
3. SEX Female	4. RACE White	5. DATE OF BIRTH (MONTH DAY YEAR) Feb 25, 1948	6. AGE (IN YEARS) (BIRTHDAY) 34 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Dec 19 1982		2b. HOUR 1:50 PM			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland										13b. COUNTY Montgomery	
13c. CITY OR TOWN Silver Spring										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 8916 First Avenue											
14. FATHER'S NAME FIRST MIDDLE LAST Israel Kobrin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary (Unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-74-8398			17. INFORMANT ADDRESS Pearl S. Carpel (Same as # 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8880 IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Fracture L. tibia & fibula											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall in nursing home						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE McCombs Ave, Kensington Mont Md						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers, M. D.			TITLE (SPECIFY) M.D. Dep.			MEDICAL EXAMINER 1919 Seminary Road, Silver Spring, Maryland			DATE SIGNED Dec 6/1982		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/7/1982		23c. NAME OF CEMETERY OR CREMATORY D. C. Lodge Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Washington D. C.			
24. DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.					25a. DATE REC'D BY REGISTRAR DEC 10 1982					25b. REGISTRAR'S SIGNATURE John J. Conner	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 7 5 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Moody H Sanders				2a. DATE OF DEATH MONTH DAY YEAR 12-11-82		2b. HOUR 1440	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec, 7 1899		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY, MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY PEPCO	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Sanders		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Unknown		13e. STREET ADDRESS 12700 Glen Mill Road		zip 20854	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 579 03 1483		17. INFORMANT ADDRESS Lucille S. Sanders, wife see # 13			
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4960 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST } CHRONIC Pulmonary Obstructive Disease DUE TO, OR AS A CONSEQUENCE OF } (c) year				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Shingles							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 12/11/82 to 12/11/82 that (1) the last saw the deceased alive on 12/11/82, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) was told (did not) view the body after death.							
22b. SIGNATURE Thos G. Ward				DEGREE M.D.		22c. DATE SIGNED 12/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward				22e. ADDRESS 6116 Robinwood, Bethesda, MD 20817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/transit		23b. DATE 12/16/82		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Portsmouth, Independent City Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25. DATE REC'D. BY REGISTRAR DEC 17 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	
P.A. Bethesda, Maryland							

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 5 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KLARA SARANO			2a. DATE OF DEATH MONTH DAY YEAR December 21, 1982		2b. HOUR 2:00p.m.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Izmir, Turkey		7b. CITIZEN OF WHAT COUNTRY? Turkey		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) #7 Crest Park Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST CHAIM SARDAS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Jale' Penzo; #7 Crest Park Court;			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b)

CARDIAC ARRHYTHMIA

DUE TO, OR AS A CONSEQUENCE OF

(c)

CORONARY HEART DISEASEAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 2/23 , 19 81 , to 12/20 , 19 82 , that (2) (we) lost saw the deceased alive on 12/19/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Steven K. Kaufman				DEGREE MD		22c. DATE SIGNED 12-21-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN K. KAUFMAN, MD				22e. ADDRESS Maryland 8830 Cameron Street, #404; Silver Spring			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Dec. 22, 82		23c. NAME OF CEMETERY OR CREMATORY JUDEAN MEM. GDNS.		23d. LOCATION CITY OR TOWN COUNTY STATE OLNEY; MONTGOMERY; MARYLAND	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25. DATE REC'D BY REGISTRAR DEC 27 1982			
1170 Rockville Pike; Rockville, Maryland 20852				26. REGISTRAR'S SIGNATURE John J. Carver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

OLNEY; MONTGOMERY; MARYLAND

JOHN HENRY CHAPLAIN
JOHN HENRY CHAPLAIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 working days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it should be marked on the back of this certificate.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 5 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Wayne Thomas Sawyer			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1982			2b. HOUR 8:10a M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 20, 1950		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler		12b. KIND OF BUSINESS OR INDUSTRY U.A.W.		
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 715 Fernhill Road 21226	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest L. Sawyer, Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty L. Schweitzer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-56-4340		17. INFORMANT Mary Ann Sawyer (wife)			ADDRESS same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardiac Failure post open heart surgery								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								(b) Coronary Artery Disease Years (c) Percutaneous Coronary Angioplasty with Myocardial Infarction 24 hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Hodgkin's Disease										
19a. DATE OF OPERATION December 16, 1982			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 11, 1982 , to December 17, 1982 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 17, 1982 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.										
22b. SIGNATURE Steven R. Cohen DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/17/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven R. Cohen, M.D.						22e. ADDRESS The Clinical Center, NIH, 9000 Rockville Pike, Bethesda, Maryland 20205				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/20/1982		23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc.			23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto., Md.			
24. FUNERAL DIRECTOR NAME McCurly Funeral Homes Balto., Md., 21225 237 E. Patapsco Ave.,						25a. DATE REC'D. BY REGISTRAR DEC 21 1982 REGISTRAR'S SIGNATURE J. J. J. Carver				

... ..

15:12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 7 5 5	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (PRINT OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Palmer Carmen			Scarnecchia			Dec 27 1982			3 ³⁰ P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS. HOURS MIN.	
Male		Caucasian		March 14, 1915		67 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Ohio		United States				Montgomery MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban Hospital			Civil Defense			U.S. Gov't		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
Maryland			Montgomery		Bethesda		YES		5409 Glenwood Road 20817 zip		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Carmen Scarnecchia			Angela Maria Scarnecchia								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
no			216 44.3583		Mary F. Scarnecchia see #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
4910 IMMEDIATE CAUSE (a) Respiratory Arrest.											
DUE TO, OR AS A CONSEQUENCE OF (b) Severe Emphysema, Bronchitis											
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Smoker, Respiratory Infection											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Carcinoma Right upper lobe with metastasis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-10-1982 to 12-27-1982 that (I) (we) lost saw the deceased alive on 12-27-1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Roland Imperialis									12-27-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
ROLAND IMPERIALIS			4977 BATTERY LANE BETHESDA								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			Dec. 30		Parklawn Memorial Park		Rockville, Maryland				
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Robert A. Pumphrey Funeral Homes, P.A.			Bethesda, Maryland			1 JAN 5 1983			John J. Carver		

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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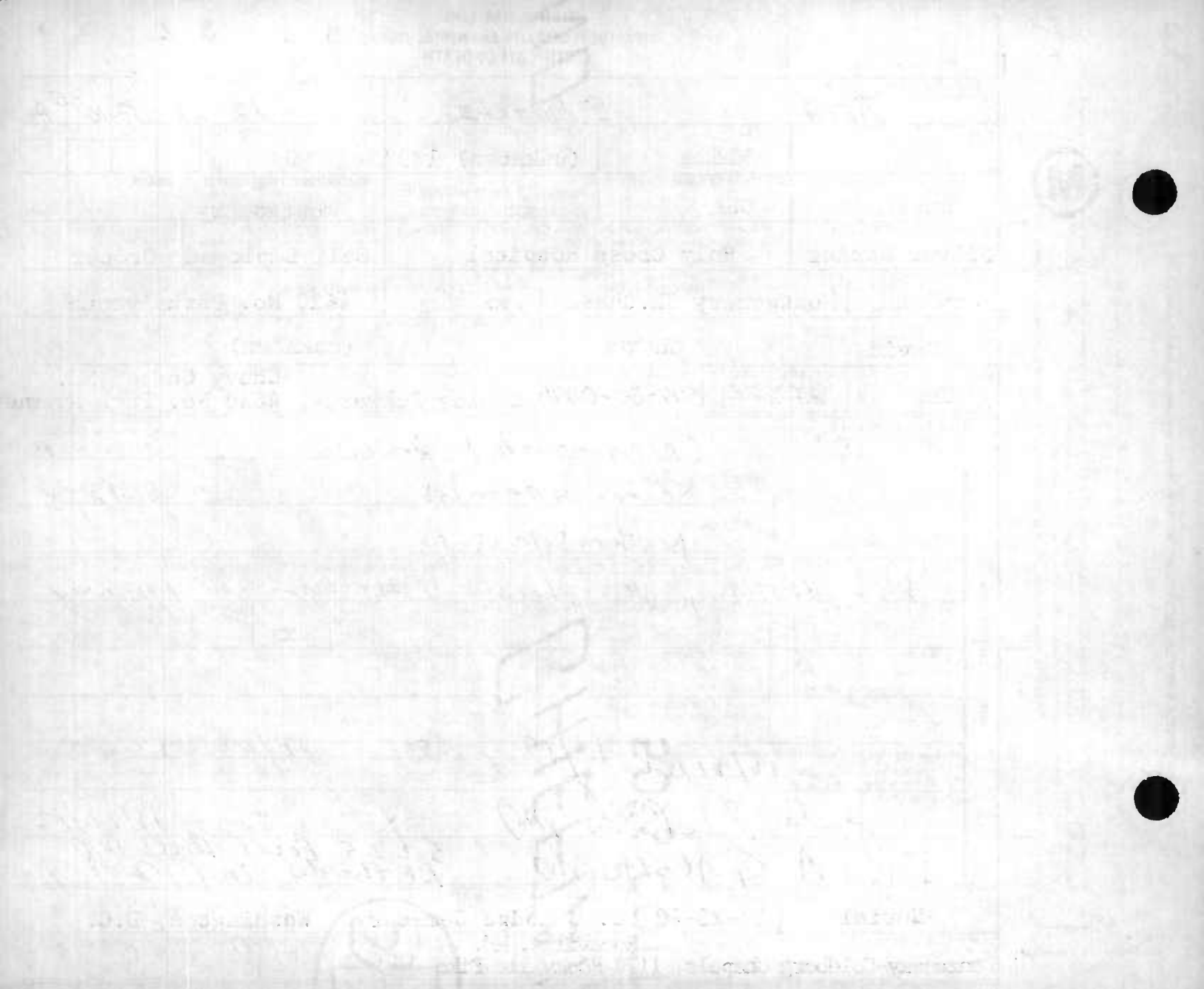
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KEVA Schwartz			2a. DATE OF DEATH MONTH DAY YEAR 12 22 1982		2b. HOUR 10⁵⁵ AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR (unknown) 1892		6. AGE (IN YEARS LAST BIRTHDAY) 90
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Grocer
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Ch. Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST David Chorne			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW-1----		17. INFORMANT ADDRESS Stanley Schwartz; 4620 No. Park Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest 4039 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Severe Uremia DUE TO, OR AS A CONSEQUENCE OF (c) Nephrosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 minutes 5 days						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dehydration, Peripheral Vascular Insufficiency						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/19 19 82 to 12/22 19 82 , that (I) (we) lost saw the deceased alive on 12/22/1982 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE John A. Galotto		22c. ADDRESS 5225 Rock Hill Rd Bethesda, Md 20814		22d. DATE SIGNED 12/22/82		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Galotto		22f. ADDRESS 5225 Rock Hill Rd Bethesda, Md 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-23-82		23c. NAME OF CEMETERY OR CREMATORY D. C Lodge Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapsels; 1170 Rockville Pike				
25a. DATE REC'D. BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE John J. Carver				

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA LEE SCOTT					2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 14, 1982			2b. HOUR 12:00 PM		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAY 27, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 9 GEORGIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12625 LAYHILL ROAD APT. 201				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOL TEACHER		12b. KIND OF BUSINESS OR INDUSTRY NORWOOD SCHOOL		
13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT SCOTT					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGNOLIA SCOTT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1962-1966		17. INFORMANT HAZEL WELLS, SISTER, SILVER SPRING, MD.		ADDRESS 12625 LAYHILL RD. #201 20906				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE 1950 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CANCER OF THE LIVER 8 months DUE TO, OR AS A CONSEQUENCE OF (c) ADENOCARCINOMA OF THE LIVER 4 1/2 yrs.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE MONTH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. NONE										
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> N/A			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 10/5, 1979, to 12/14, 1982, that (I) (we) last saw the deceased alive on 12/14, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) enter the body after death.										
22b. SIGNATURE Gary R. Burch, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/14/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary R. Burch, M.D.					22e. ADDRESS 3301 New Mexico Ave., Wash, D.C. 20016					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/16/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT. MD.		
24. FUNERAL DIRECTOR NAME RICHARD RAPP INC.					25a. DATE RECD. BY REGISTRAR DEC 23 1982			25b. REGISTRAR'S SIGNATURE [Signature]		
25c. ADDRESS 3520 CONN. AVE. N.W. WASH. D.C. 20008										

BP



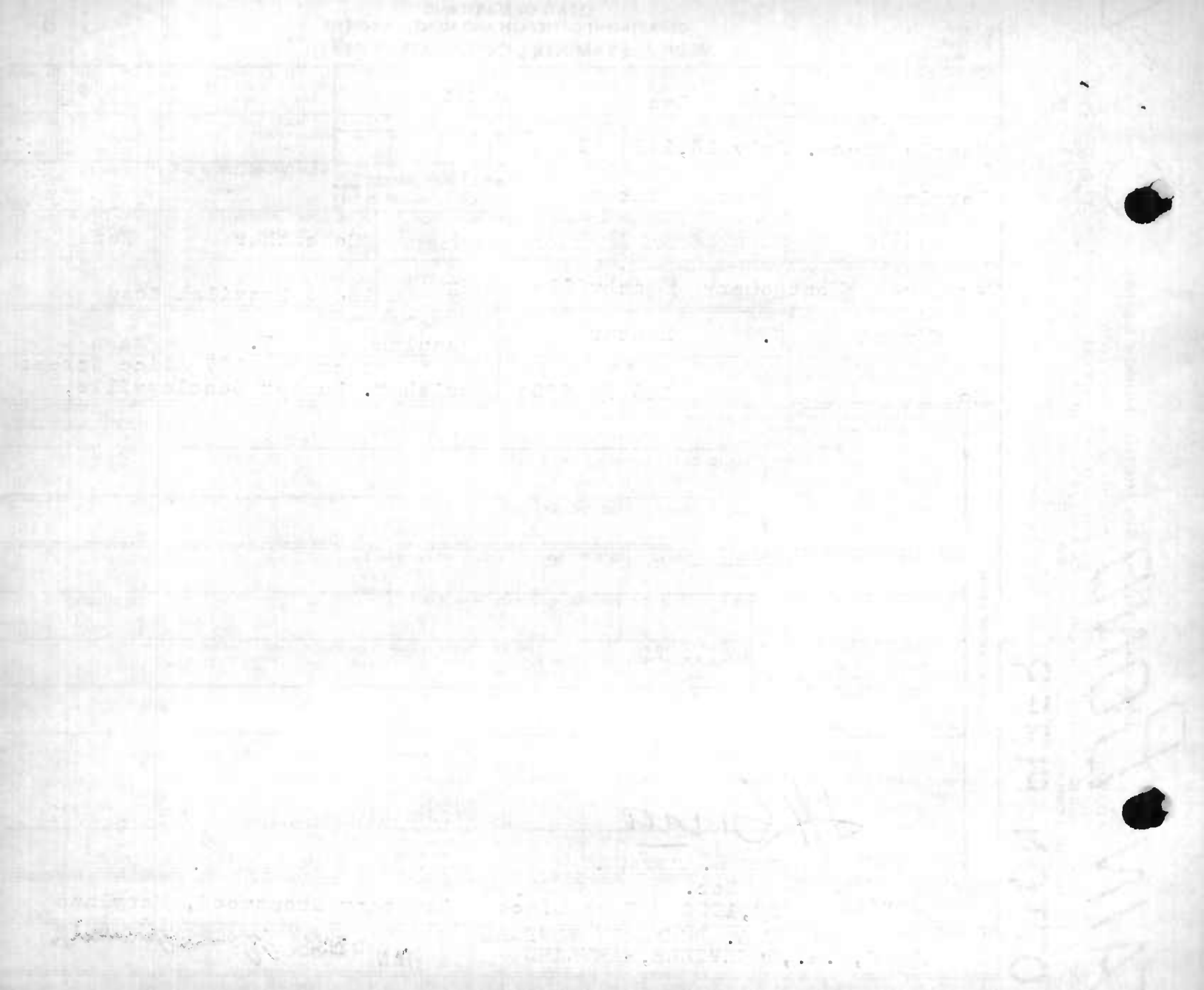
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 2018-2019
 2020-2021
 2022-2023
 2024-2025

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 7 5 8		
1- FOR STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT) Bonnie Lee Seabolt							2a. DATE KNOWN OF DEATH XX MONTH 12 DAY 27 YEAR 82		2b. HOUR 6:37 AM			
3. SEX Female		4. RACE Cauca.		5. DATE OF BIRTH MONTH July DAY 28 YEAR 1950		6. AGE (IN YEARS) LAST BIRTHDAY 32 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 		2c. DATE PRONOUNCED DEAD MONTH 12 DAY 27 YEAR 82		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland			13b. CITY OR TOWN Montgomery			13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13866 Travilah Road	
14. FATHER'S NAME Edward S. Hunter						15. MOTHER'S MAIDEN NAME Beulah V. Fagen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219 54 9934				17. INFORMANT Mother ADDRESS 317 Alice Street Beulah V. Hunter Bentleyville, PA				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE H R Guard						TITLE (SPECIFY) Assistant			DATE SIGNED 12/28/82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.						ADDRESS 111 Penn Street, Balto. MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 30, 1982			23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood, Maryland STATE			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND						25a. DATE REC'D. BY REGISTRAR JAN 5 1983			25b. REGISTRAR'S SIGNATURE [Signature]			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5. IF BURIAL FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 7 5 9	
1. DECEASED NAME (TYPE OR PRINT) Jack										2a. DATE KNOWN OF DEATH MONTH 12 DAY 24 YEAR 1982	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH 11 DAY 18 YEAR 1937		6. AGE (IN YEARS) MONTHS 45 YEARS 45		7. IF UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN 0		2b. DATE PRONOUNCED DEAD MONTH 12 DAY 24 YEAR 1982	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Antique Dealer		12b. KIND OF BUSINESS OR INDUSTRY Antiques	
13a. STATE FLA		13b. COUNTY BROWARD		13c. CITY OR TOWN Hollywood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1815 S. Ocean Dr.			
FATHER'S NAME FIRST (NOT KNOWN) MIDDLE (NOT KNOWN) LAST Seigal				15. MOTHER'S MAIDEN NAME FIRST DORA MIDDLE (NOT KNOWN) LAST (NOT KNOWN)				ADDRESS 625 Piping Rock Dr.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 070-2830-364		17. INFORMANT Arlene Wozin		ADDRESS Silver Spring, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER 1919 Seminary Rd. S.S. MD		DATE SIGNED Dec 24/82	
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS 1919 Seminary Rd. S.S. MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/27/82		23c. NAME OF CEMETERY OR CREMATORY New Montefiore Cem.		23d. LOCATION CITY OR TOWN Long Island STATE N.Y.			
24. FUNERAL DIRECTOR NAME TAKOMA FUNERAL HOME ADDRESS N.W. WASH. D.C.				25. DATE RECORDED DEC 29 1982		26. REGISTRAR'S SIGNATURE John S. Rogers					

12/27/82 New Bedford Co. New York N.Y.
12/27/82 New Bedford Co. New York N.Y.
12/27/82 New Bedford Co. New York N.Y.

John J. Jones
12/27/82

070-2830-364 Ariene Wozin Silver Spring, MD
635 Epping Road Tr.
(over known)
Dora

Antiquities Dealer Antiquities
U.S.A.
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 6 0 REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST Charles Nathan Sellers				December 8 1982				4:15 P.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov 1, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRLAND NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PARKING LOTS		12b. KIND OF BUSINESS OR INDUSTRY OWNER			
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2804 URBANA DRIVE	
14. FATHER'S NAME FIRST MIDDLE LAST NATHAN SELLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KEITH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 504-32-4516		17. INFORMANT DAUGHTER		ADDRESS GLADYS SELLERS HEDSTROM SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) S/P Complete heart block perm. pacemaker DUE TO, OR AS A CONSEQUENCE OF (c) Coronary heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 year > 5 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebral arteriosclerosis. Gastrointestinal bleeding due to stress											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 9/12, 1981 to 12/8, 1982; that (1) we lost saw the deceased alive on 11/27, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (1) we (did) (did not) view the body after death.											
22b. SIGNATURE George S. Kenton, MD				DEGREE				22c. DATE SIGNED 12/8/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE S. KENTON				22e. ADDRESS 10620 Georgia Ave, Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 12/9/82		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA			
24. FUNERAL DIRECTOR Francis J. Collins Funeral Home Inc. 500 UNIV. BLVD., W., SILVER SPRING, MD.				25a. DATE REC'D. BY REGISTRAR DEC 13 1982				25b. REGISTRAR'S SIGNATURE John G. Carver			

December 8 1962

Section

Class

Composition

Date



Francis J. Collins Tunnel Home Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 7 6 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ALBERT GORDON SENTMAN				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 28 1982		2b. HOUR 1:52 a	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 28 1918		6. AGE (IN YEARS LAST BIRTHDAY) 64	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY FLORIDA BREVARD				13b. CITY OR TOWN SATELLITE BEACH		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT FRANCIS SENTMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MYRTLE MAE DETTRA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1935-1965		17. INFORMANT ADDRESS EDNA L. SENTMAN, 200 CHERRY DRIVE, SATELLITE BEACH, FL 32937			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) PNEUMONIA, POST RIGHT PNEUMONECTOMY FOR DUE TO, OR AS A CONSEQUENCE OF (b) SQUAMOUS CELL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from DECEMBER 9, 1982 to DECEMBER 28, 1982 , that (we) last saw the deceased alive on DECEMBER 28, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>P. A. Tibbits</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. A. TIBBITS, CDR MC USN				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 31, 1982		23c. NAME OF CEMETERY OR CREMATORY Florida Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Cocoa, Florida	
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, Va.				25a. DATE REC'D. BY REGISTRAR JAN 3 1983			
				25b. REGISTRAR'S SIGNATURE <i>John J. Lohr</i>			

GEY

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 6 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
DENNIS JEROME SEVERSON, SR.				DECEMBER 31, 1982				7:25 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE		WHITE		FEBRUARY 14, 1934		48		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
North Dakota		USA				MONTGOMERY COUNTY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		CLINICAL CENTER, NIH, BETHESDA, MD; Chemical Production		Engr					
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
NORTH DAKOTA		TIOGA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. BOX #543		58852	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Oscar		Ada		yes		578-52-419		ROSELEE SEVERSON, Wife (Same as Pt.)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:		2000 IMMEDIATE CAUSE (a)		HEMORRHAGIC PNEUMONITIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF		(b)		DIFFUSE HISTIOCYTIC LYMPHOMA WITH EXTENSIVE					
DUE TO, OR AS A CONSEQUENCE OF		(c)		MULTI-ORGAN INVOLVEMENT					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 26 82 to December 31 82 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 31 19 82 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED					
Frederick Peter Ognibene, MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1/1/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Frederick Peter Ognibene, MD		NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205		Burial		Jan 5, 1983		Zion Lutheran Cem.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
Marshall's Funeral Home		4217 9th Street NW, Washington, D.C.		JAN 10 1983		John J. Lauer			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY



PLANT INDUSTRY

UNITED STATES DEPARTMENT OF AGRICULTURE



UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) John J. Sexton					2a. DATE OF DEATH MONTH DAY YEAR 12 27 82					2b. HOUR 10:45 AM
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 26 1930		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5822 Highland Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY Law Firm		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 20815		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5822 Highland Drive		
14. FATHER'S NAME FIRST MIDDLE LAST John Joseph Sexton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rita Morris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 018-22-1628		17. INFORMANT ADDRESS Janet H Sexton. Same as item 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER METASTASES DUE TO, OR AS A CONSEQUENCE OF (b) COLON CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 6 YEARS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1539										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from July 26 , 19 76 , to DECEMBER 27 , 19 82 , that (I) (we) lost saw the deceased die on DECEMBER 27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Harold S. Mirsky				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/27/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold S Mirsky, M.D.				22e. ADDRESS 730-24th St., N.W. Wash., D.C. 20037						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/30/1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland.				
24. FUNERAL DIRECTOR Joseph Lawler's Sons, Inc. 5130 Wisc. Ave., N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR 1 JAN 3 1983		25b. REGISTRAR'S SIGNATURE John J. Conner				

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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John H. Dutton, Jr., Editor

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 3 2 7 6 4 | |
|---|--|---|---|--|--|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM M. SHEARN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR December 5, 1982 | | | 2b. HOUR 4:06 am | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 15 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ins. Broker | | 12b. KIND OF BUSINESS OR Patterson Associates | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Ashton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1011 Ashton Road, | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William J. Shearn | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Alice Meredith | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW 11 407-26-4068 | | 17. INFORMANT ADDRESS 13 Vienna Court, Maureen S. Skelly-Dau-Frederick, Md. 21701 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2030 MALIGNANT MELANOMA | | | | | | | | | | 1 YEAR | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 1981 to DEC. 5, 1982 , that (I) (we) lost saw the deceased alive on DEC. 5, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Eugene P. Flannery, MD DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 12/5/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY | | | | | | 22e. ADDRESS 1811 PRINCE PHILIP DR. OLNEY, MD. 20832. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 12-6-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC | | | |
| 24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home | | | | | | 11800 N.H. Avenue, Silver Spring, Md. | | 25a. DATE REC'D BY REGISTRAR DEC 7 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |

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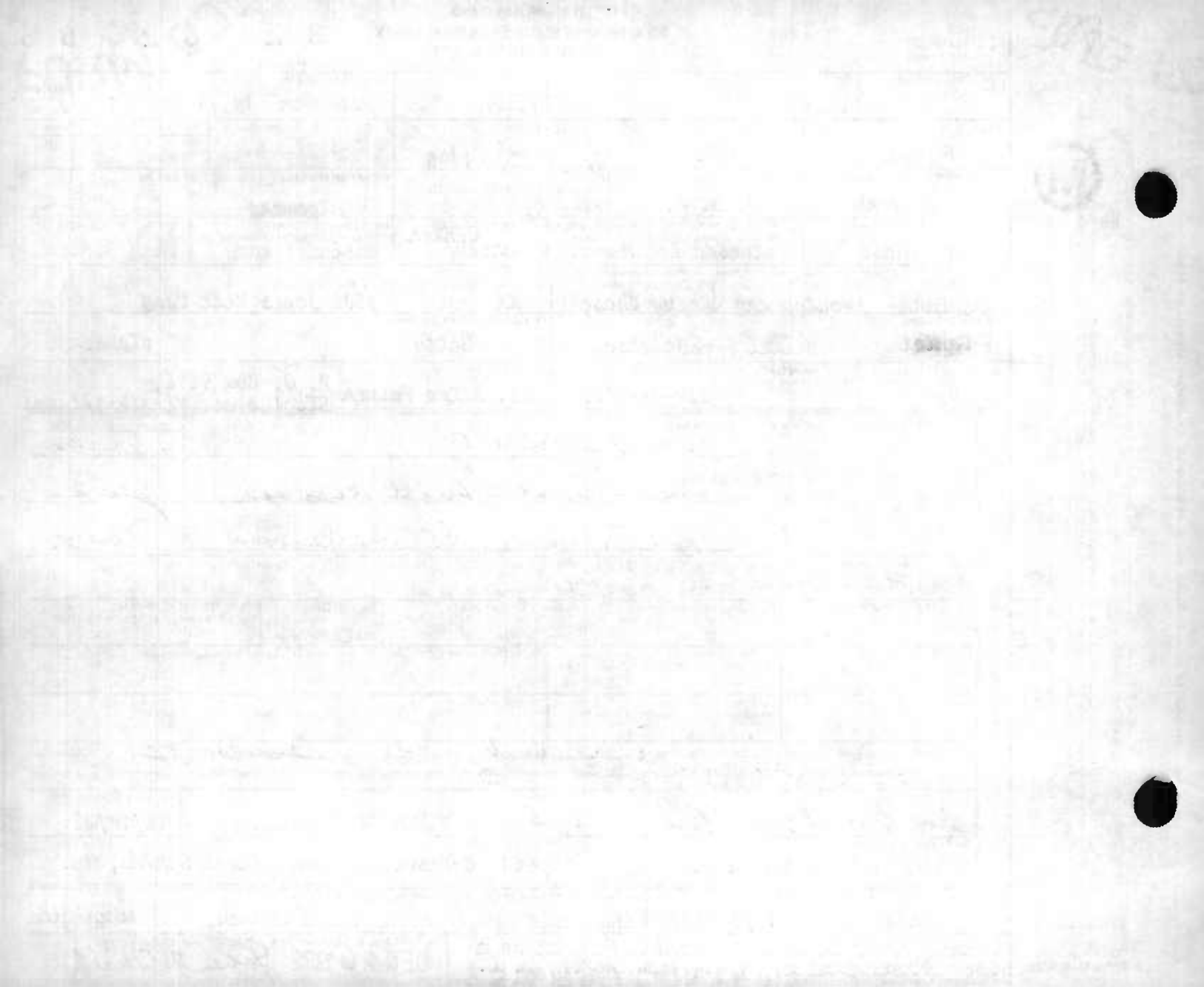
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|------------------------------------|--|---|--|--|--|----------|--|-------|--|
| 1. FOR STATE REGISTRAR | | 8 2 3 2 7 6 5 | | REG. NO. | | | | | | | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | MIN. | |
| HELEN | | | | | | SHEFTELMAN | | December 14, 1982 | | | | | | | | 12:00 | | Noon | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Female | | White | | July 2, 1895 | | 87 YRS. | | New York | | U. S. A. | | | | Montgomery | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Chevy Chase | | Bethesda Retirement & Nursing Center | | Business Lady | | Drug Store | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | Montgomery | | Chevy Chase | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8700 Jones Mill Road | | | | | | | | | | | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| Daniel | | Hillel | | Jacobson | | Betty | | Richter | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | | | | | | | | | | | | | | |
| No | | 229-44-9085D | | Mrs. Selma Posner | | P. O. Box 9296, ST. Thomas, Virgin Islands | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | 4140 | | DUE TO, OR AS A CONSEQUENCE OF (b) | | arteriosclerotic heart disease | | DUE TO, OR AS A CONSEQUENCE OF (c) | | generalized arteriosclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 2 weeks | | years | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| Recent hypotension & septicemia | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION | | | | | | | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (II) (we) did not view the body after death. | | 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | | | | | |
| | | Sydney Leventhal, M. D. | | M. D. | | | | 12/14/82 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | | | |
| Burial | | 12/16/1982 | | King David Mem. Garden | | Falls Church, Virginia | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Donald M. Stein Hebrew Memorial Funeral Home | | DEC 20 1982 | | John J. Canine | | | | | | | | | | | | | | | |
| 232 Carroll Street, N. W., Washington, D. C. | | | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 1 6 6

REG. NO.

| | | | | | |
|---|--|--|--|----------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 7b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2b. DATE OF DEATH MONTH DAY YEAR | | 7b. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | HOURS MIN. | |
| LISA Beth SHERER | | Dec 8 1982 | | 7 44 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR | 27 YRS | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Wash., D.C. | U. S. A. | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Silver Spring | Holy Cross Hospital | | Student | | School |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13e. STREET ADDRESS | | |
| Maryland | Montgomery | Bethesda | 8520 West Howell Road | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | ADDRESS | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | | ADDRESS | | |
| Max G. Sherer | Leah Lipschutz | | 8520 West Howell Rd. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | | |
| No | 220-70-7233 | Dr. Max G. Sherer Bethesda, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) UREMA | | | | | 1 WK |
| 5860 DUE TO, OR AS A CONSEQUENCE OF (b) RESECTION OF KIDNEY TRANSPLANT | | | | | 11 MO |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETIC GLOMERULOSCLEROSIS. HYPERTENSION | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from JUNE 19 82 to 8 Dec 19 82, that (I) (we) lost saw the deceased alive on 8 DEC 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death. | | | | | |
| 22b. SIGNATURE (Type or Print) | | | | | 22c. DATE SIGNED |
| Ira N. Tublin, M. D. | | | | | 8 Dec 82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS |
| Ira N. Tublin, M. D. | | | | | 8830 Cameron St., Sil. Spr., Md. |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | 12/12/82 | Garden | Falls Church, Va. | | |
| 24. FUNERAL DIRECTOR NAME | 24b. ADDRESS | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Warner E. Pumphrey, Inc. | P.O. Box 7428 Sil. Spr., Md. | DEC 15 1982 | | John J. Connel | |

OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

MEMORANDUM FOR THE SECRETARY OF DEFENSE

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 6 7

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) MYRTLE A SHREVE | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-25-82 | | 2b. HOUR
4:35 M | |
| 3 SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 21 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jacob F. Alt | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie C Kimble | | 13e. STREET ADDRESS
7718 Bradley Blvd | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
233-58-2992 | | 17. INFORMANT
ADDRESS
Mrs. M. Ruth Bradley see 13 E | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c) 4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Upper GI bleeding & azotemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs | | | | | | | |
| 19a. DATE OF OPERATION
12/24 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Upper GI bleeding & azotemia | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/24 , 19 82 , to 12/25 , 19 82 , that (I) (we) lost saw the deceased alive on 12/24 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John W. Chambers MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LEWIS N. CHAMBERS MD | | 22e. ADDRESS
5411 W. CEDAR LN. BETHESDA, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-29-1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Keyser Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Keyser, Mineral, W. Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W. W. Chambers Co, 8655 Georgia Ave, S. S. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1982 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | |

BP

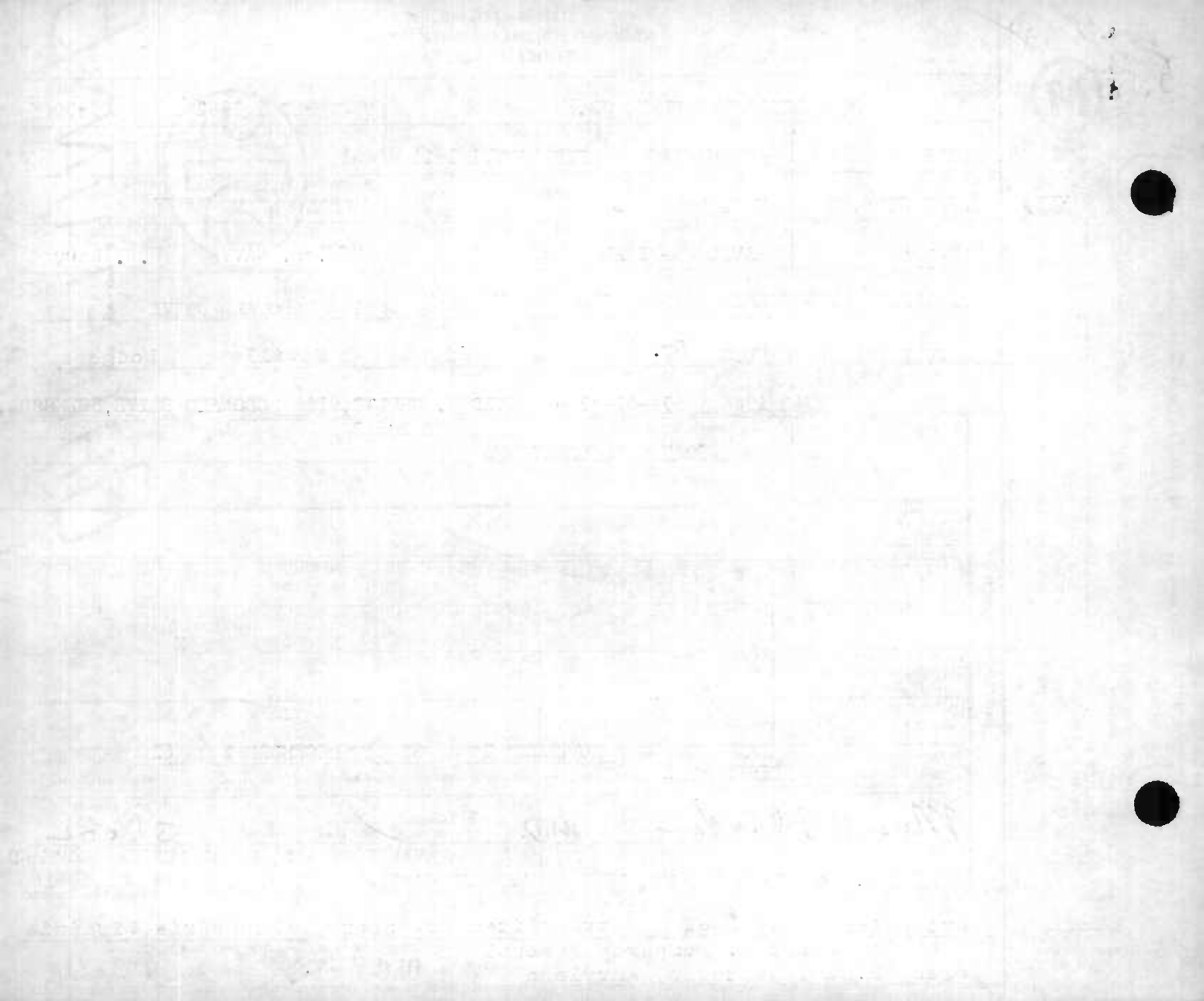
single file

Can I not deliver it

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 3 2 7 6 8 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
JOHN WILLIAM SHULTZ, JR. | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 2 1982 | | 2b. HOUR
9:36 P M | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
FEBRUARY 1 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, DC | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Officer | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BETHESDA | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOHN WILLIAM SHULTZ Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Edith Seville Hodgson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1942-1964 579-07-8704 | | 17. INFORMANT ADDRESS
MAVIS E. SHULTZ, 9118 MCDONALD DRIVE, BETHESDA, MD 20817 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) OAT CELL CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: MD 20817 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 2, 1982 , to DECEMBER 2, 1982 , that (I) (we) last saw the deceased alive on DECEMBER 2, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Marion R. McMullan</i> | | | | DEGREE
M.D. | | 22c. DATE SIGNED
3 Dec 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARION R. McMILLAN, LT, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
December 4, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 6 - 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST ROSA | | MIDDLE B. | | LAST SIMON | | 2a. DATE OF DEATH | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
AUGUST 2, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 | | 7b. HOUR
2:38 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY | | 12b. KIND OF BUSINESS OR INDUSTRY
LABOR DEPARTMENT | |
| 10. CITY OR TOWN OF DEATH
WHEATON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
UNIVERSITY NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. GOVERNMENT | | 12b. KIND OF BUSINESS OR INDUSTRY
LABOR DEPARTMENT | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
506 BURNT MILLS AVENUE | |
| 14. FATHER'S NAME
FIRST JACOB MIDDLE SCHOFTER LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST LENA MIDDLE MEYER LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-46-6393 | | 17. INFORMANT
ANNE GORMAN, 506 BURNT MILLS AVENUE, SILVER SPRING, MARYLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cerebrovascular</u>
<u>4349</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>cerebral infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pneumonia, bilateral</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>1 month</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-4-82</u> to <u>12-4-82</u> , that (I) <u>did not</u> last saw the deceased alive on <u>11-27-82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I <u>have</u> <u>not</u> <u>seen</u> the body after death.) | | | | | | | | | |
| 22b. SIGNATURE
<u>John J. Carver</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>12-4-82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>John J. Carver, M.D.</u> | | | | 22e. ADDRESS
<u>8830 CARRINGTON ST.
SILVER SPRING, MD. 20910</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
12/5/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
KING DAVID MEMORIAL GARDEN | | 23d. LOCATION
FALLS CHURCH, VIRGINIA | | | |
| 24. FUNERAL DIRECTOR
NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 1982 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Carver</u> | | | | | |

BP



UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 3 2 7 7 0 | |
|--|--|---|--|---|--|--|--|---|--|---------------|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Rosalie B. Singer</i> | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12-21-82</i> | | 2b. HOUR
<i>4:00 A.M.</i> | | | |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>WHITE</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>8-19-04</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>78</i> | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
<i>VIRGINIA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY COUNTY</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>KENSINGTON</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
<i>KENSINGTON GARDENS NURSING HOME</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR BUSINESS DURING LIFE)
<i>SECRETARY</i> | | 12b. KIND OF BUSINESS OR
<i>FEDERAL GOVERNMENT</i> | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
<i>MARYLAND</i> | | 13b. COUNTY
<i>MONTGOMERY</i> | | 13c. CITY OR TOWN
<i>SILVER SPRING</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>1400 FENWICK LANE, APT. 312</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>DAVID BUSKY</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>REBECCA MICHAELSON</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>579-01-1525 B</i> | | 17. INFORMANT
ADDRESS
<i>1400 FENWICK LANE, APT. 312
SAMUEL SINGER, SILVER SPRING, MARYLAND</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary vascular incident a occlusion</i>
<i>4360</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Essential Hypertension</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>25 years.</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
<i>chronic cystitis, osteoporosis, Liver Curcans</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 15</i> , 19 <i>82</i> , to <i>12/18</i> , 19 <i>82</i> , that (I) (we) last
saw the deceased alive on <i>12/18</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Max G. Sherer MD</i> | | | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/21/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MAX G. SHERER MD</i> | | | | 22e. ADDRESS
<i>800 PERSHING DRIVE SILVER SPRING, MD 20910</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
<i>BURIAL</i> | | 23b. DATE
<i>12/22/1982</i> | | 23c. NAME OF CEMETERY OR CREMATOR
<i>CHIEV SHOLOM PALMUD TORAH CONGREGATION CEMETERY</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>WASHINGTON, D. C.</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>RONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</i> | | | | 25. DATE PREPARED BY ATTENDING PHYSICIAN
<i>DEC 27 1982</i> | | 26. REGISTRAR'S SIGNATURE
<i>John J. Lauer</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
John F Skillman | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 02 82
2b. HOUR
7:00 ^a M | | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 19 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | | | |
| 10. CITY OR TOWN OF DEATH
POTOMAC | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10021 NEWHALL ROAD | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SPECIAL ASSISTANT | | 12b. KIND OF BUSINESS OR INDUSTRY
DEPT. OF COMM | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
POTOMAC | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROYER N. SKILLMAN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MINNIE WESCO | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
303-01-0164 | | 17. INFORMANT ADDRESS
DOROTHY SKILLMAN, WIFE, POTOMAC, MD. 20854 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>
4149
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Coronary artery disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate
15 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>Chronic obstructive pulmonary emphysema</u> 25 years | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November 16</u> 19 <u>87</u> to <u>November 19</u> 19 <u>82</u> , that (I) (we) lost
saw the deceased alive on <u>November 19</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u>
DEGREE | | | | 22c. DATE SIGNED
12/2/82 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GERALD I. SHUGOLL, M.D. | |
| 22e. ADDRESS
5530 Wisconsin Ave., Chevy Chase, Md. 20815 | | | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF
DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
12/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SWITLAND PG. MD. | | 23e. DATE REC'D. BY REGISTRAR
DEC 6 1982 | |
| 24. FUNERAL DIRECTOR
NAME
RICHARD RAPP CREMATION SVC'S
3520 CONN AVE N.W. WASH D.C. 20008 | | | | | | | | | |
| 25. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 2 3 2 7 7 2
REG. NO. | |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Frank E Smallman | | 2a. DATE OF DEATH MONTH DAY YEAR Dec 27, 1982 | | 2b. HOUR 4:04 M | |
| 3. SEX MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR NOV 17, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AERO. ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY VITRO |
| 13a. STATE MARYLAND | 13b. COUNTY MONTGOMERY | 13c. CITY OR TOWN WHEATON | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 2712 HENDERSON AVENUE 20902 | |
| 14. FATHER'S NAME FIRST FRANCIS MIDDLE EDWARD LAST SMALLMAN | | 15. MOTHER'S MAIDEN NAME FIRST ROSANNA MIDDLE HADDAWAY LAST HADDAWAY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 129-03-3157 | | 17. INFORMANT SON 10851 RUNAWAY LANE
STEPHEN E. SMALLMAN GREAT FALLS, VA. 22066 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) Small cell carcinoma of Lung
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED _____ | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____ | | 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____ | |
| 22a. I certify that (I) (the hospital) attended the deceased from NOV 8, 1982 to 12/27, 1982 , that (I) (we) last saw the deceased alive on 12/27, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE G. Lennard Gold, M.D. | | DEGREE ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. LENNARD GOLD | | 22e. ADDRESS SILVER SPRING, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 12/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN | |
| 23d. LOCATION CITY OR TOWN ALEXANDRIA COUNTY VIRGINIA STATE _____ | | 24. FUNERAL DIRECTOR FRANCIS J. COLLINS
NAME 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 ADDRESS _____ | | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 6 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 3 2 7 7 3 | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JAMES ELLSWORTH SMITH Jr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 7, 1982 | | 2b. HOUR
2:28 ^a _M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
DEC. 12, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.
51 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY, MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CLINICAL CENTER (NIH) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Asbury Park Press | | 12b. KIND OF BUSINESS OR INDUSTRY
Newspaper | |
| 13a. STATE
NEW JERSEY | | | | 13b. CITY OR TOWN
NEPTUNE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
James E. Smith Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Evelyn Conover | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
143-22-9488 | | 17. INFORMANT ADDRESS
MRS. DOROTHY SMITH (WIFE) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
2028 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) DIFFUSE POORLY DIFFERENTIATED LYMPHOMA
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
51 DAYS
2 YRS. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE
STREET | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from SEPT. 29, 19 82 , to DEC. 7, 19 82 , that X (we) last saw the deceased alive on DEC. 7, 19 82 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) X (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert L. Fine MD | | | | 22c. DATE SIGNED
12/7/82 | | 22d. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, NIH, BETHESDA, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-11-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Monmouth Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Tinton Falls New Jersey | |
| 24. FUNERAL DIRECTOR NAME
Francioni-Taylor & Lopez | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1982 | | 25b. REGISTRAR'S SIGNATURE
John J. Calver | |
| ADDRESS
Neptune, N. J. | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 3 2 7 7 4
REG. NO. | | | |
|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) VELMA W. SMITH | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 8, 1982 | | 2b. HOUR
11:25 PM | |
| 3. SEX
F | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
6 15 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CONN. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chief Clerk O.D.B. | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13e. STREET ADDRESS
516 Ashford Road, | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ralph C. Smith | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elinor Wiley | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) N/A | | 16b. SOCIAL SECURITY NO.
579-09-4908 | | 17. INFORMANT
Ralph C. Smith-Brother-(same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
5608 IMMEDIATE CAUSE (a) Intestinal Obstruction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Adhesions
DUE TO, OR AS A CONSEQUENCE OF
(c) 12 days
Years | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 days
Years | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive Heart Failure | | | | | | | |
| 19a. DATE OF OPERATION
3 Dec 82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Small Bowel Obstruction | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (if (this hospital) attended the deceased from 2 Dec 82 to 8 Dec 82 , that (he/she) last saw the deceased alive on 8 Dec 82 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) | | | | | | | |
| 22b. SIGNATURE
Michael Lebowitz, MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9 Dec 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael Lebowitz, MD | | | | 22e. ADDRESS
11120 New Hampshire Ave S.S. Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12-10-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, DC | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | ADDRESS
11800 N.H. Avenue,
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1982 | | | |
| | | | | REGISTRAR'S SIGNATURE
J. J. Conish | | | |

BP

2

Warrant No. 00-000000

NOTES

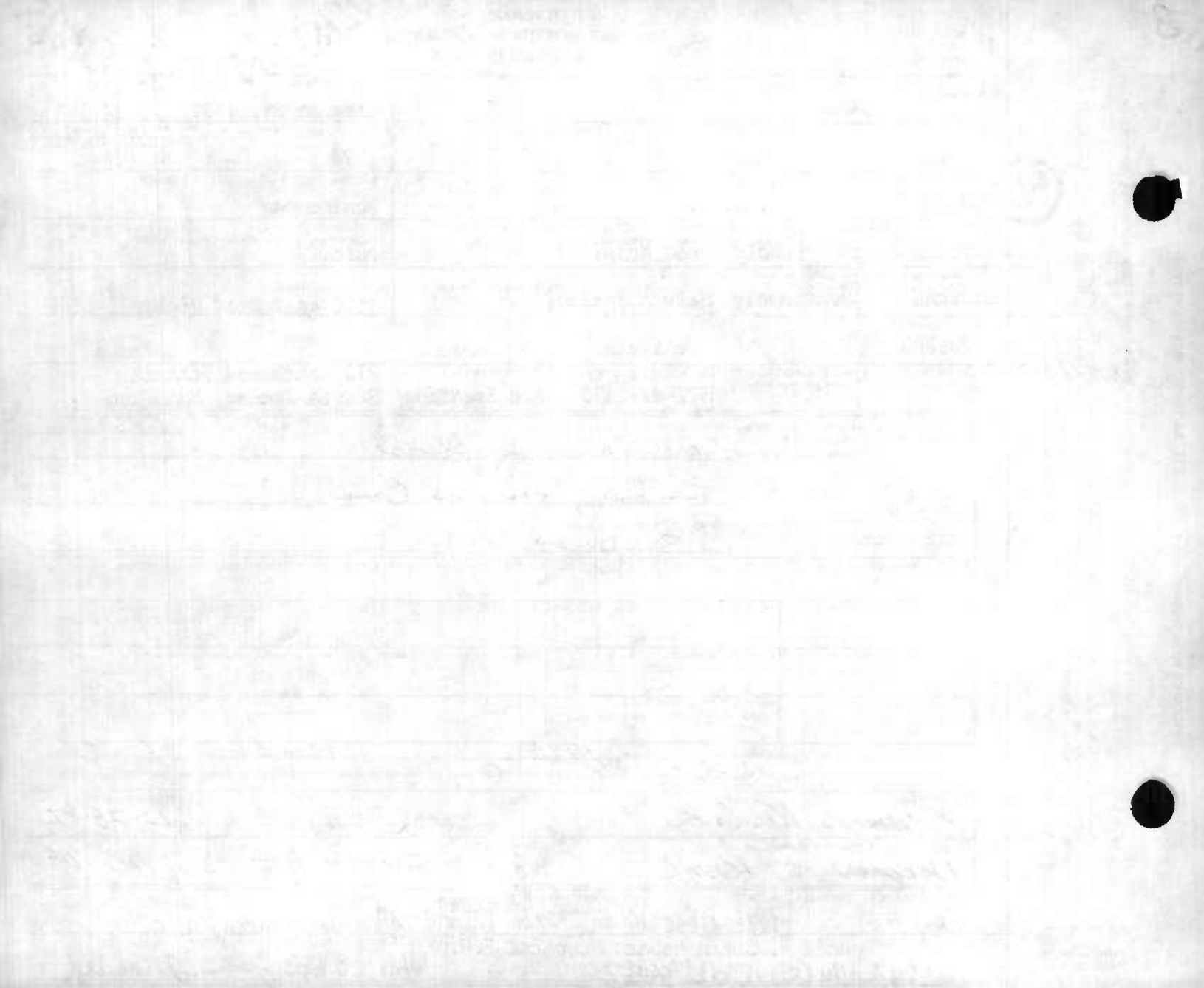
• 900-VA • • • • 46611

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 2 3 2 7 7 5 | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|-------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) SARAH | | | | MIDDLE SPERLING | | | | 2a. DATE OF DEATH MONTH DAY YEAR December 28, 1982 | | | | 2b. HOUR 4:15A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 15, 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland | | 10. CITIZEN OF WHAT COUNTRY? U. S. A. | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | |
| 13. CITY OR TOWN OF DEATH Silver Spring | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 16. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring | | | | 18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 19. STREET ADDRESS 1220 East West Highway, #305 | | | | | | | |
| 20. FATHER'S NAME FIRST MIDDLE LAST Joseph Gerstein | | | | 21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Unknown | | | | | | | | | |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 23. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-48-2693 | | 24. INFORMANT 713 Northwood Terrace Silver Spring, Maryland | | | | | | | | | |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Pulmonary Collapse | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 3484 } DUE TO, OR AS A CONSEQUENCE OF (b) INFECTION, Prolonged Coma | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Shedrenal Distention | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 26. DATE OF OPERATION | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 33. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 35. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 36. I certify that (I) (this hospital) attended the deceased from 1979 to 12-28 19 82 , that (I) (we) lost saw the deceased alive on 12-27-82 19 82 , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 37. SIGNATURE Norman S. Koval | | | | 38. DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 39. DATE SIGNED 12-28-82 | | | | | |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN S. KOVAL | | | | 41. ADDRESS 8750 GEORGIA AVE SS, MD 20910 | | | | | | | | | |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 43. DATE 12/29/1982 | | 44. NAME OF CEMETERY OR CREMATORY Cong. Cemetery | | 45. LOCATION CITY OR TOWN COUNTY STATE Ohev Sholom Talmud Torah Washington, D. C. | | | | | | | |
| 46. FUNERAL DIRECTOR NAME Donald M. Stein Hebrew Memorial F.H. | | | | 47. DATE REC'D. BY REGISTRAR JAN 3 1983 REGISTRAR'S SIGNATURE John J. Connel | | | | | | | | | |
| 48. 232 Carroll Street, N. W. Washington, D. C. | | | | | | | | | | | | | |



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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 3 2 7 7 6 | |
|--|--|--|--|---|--|---|---|--|--|---------------|--|
| 1. STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Edythe K Spitzberg | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 21 82 | | 2b. HOUR
9³⁵ P.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 13 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Chicago, Ill | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Grants Asst. | | 12b. KIND OF BUSINESS OR INDUSTRY
N. I. H. | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10124 Little Pond Pl. 20879 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Julius KXXXX Kiefe | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Etta Einhorn | | | | 16. ADDRESS
10124 Little Pond Pl. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-44-7371 | | 17. INFORMANT
Maurice Spitzberg Gaithersburg, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain stem hypoxia
5570
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hrs.
48 hrs. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Pt. suffered Cardiac arrest on operating table | | | | | | | | | | | |
| 19a. DATE OF OPERATION
12/19/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
gynegene Small Bowel | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19 , 19 82 , to 12/21 , 19 82 , that (I) (we) last saw the deceased alive on 12/21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Dr. Sandler | | | | DEGREE | | | | 22c. DATE SIGNED
12/21/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Sandler, M.D. | | | | 22e. ADDRESS
6490 Candover Rd Candover Md 20854 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gardens | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church Va. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Warner E. Humphrey, Inc. | | | | P.O. Box 7428
sil. Spr., Md. | | 25. DATE REC'D. BY REGISTRAR
DEC 27 1982 | | 26. REGISTRAR'S SIGNATURE
John J. Church | | | |

RECEIVED
JAN 10 1965



RECEIVED
JAN 10 1965

DEPT. OF THE ARMY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|--|--|--|---|---|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 82 32777 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ETHEL S. STANG | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12/25/1982 | | | 2b. HOUR 9:27 AM | |
| 3. SEX Female | | 4. RACE Cauc | | 5. DATE OF BIRTH MONTH DAY YEAR 5 1 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? US. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Cty. MD. | | | |
| 10. CITY OR TOWN OF DEATH Rockville, Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK AND MOST OF WORKING LIFE) RESEARCHER | | 12b. KIND OF BUSINESS OR INDUSTRY N.I.H. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD. CITY OR TOWN 20878 | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 14. STREET ADDRESS 17005 Longdraft Road | |
| 14. FATHER'S NAME FIRST Charles MIDDLE - LAST Small | | | | | 15. MOTHER'S MAIDEN NAME FIRST Bessie MIDDLE - LAST CLAGETT | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 216-10-1044 | | 17. INFORMANT DAVID U. STANG | | | ADDRESS SAME AS #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1552 IMMEDIATE CAUSE (a) CARCINOMA - LIVER
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CA - GASTRIC
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 2 months
2 years | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/25/82 to 12/25/82 that (I) (we) last saw the deceased alive on 12/25/82 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) saw the body after death. | | | | | | | | | |
| 22b. SIGNATURE Thos G. Ward | | | | | DEGREE | | 22c. DATE SIGNED 12/25/82 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward | | | | | 23b. ADDRESS 6116 Robinwood, Bethesda, 20817 | | | | |
| 23c. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23d. DATE DEC. 29, 1982 | | 23e. NAME OF CEMETERY OR CREMATORY Forest Oak | | 23f. LOCATION Gaithersburg Mont. Md. STATE | | |
| 24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 30 1982 | | 25b. REGISTRAR'S SIGNATURE John G. Gauer | |



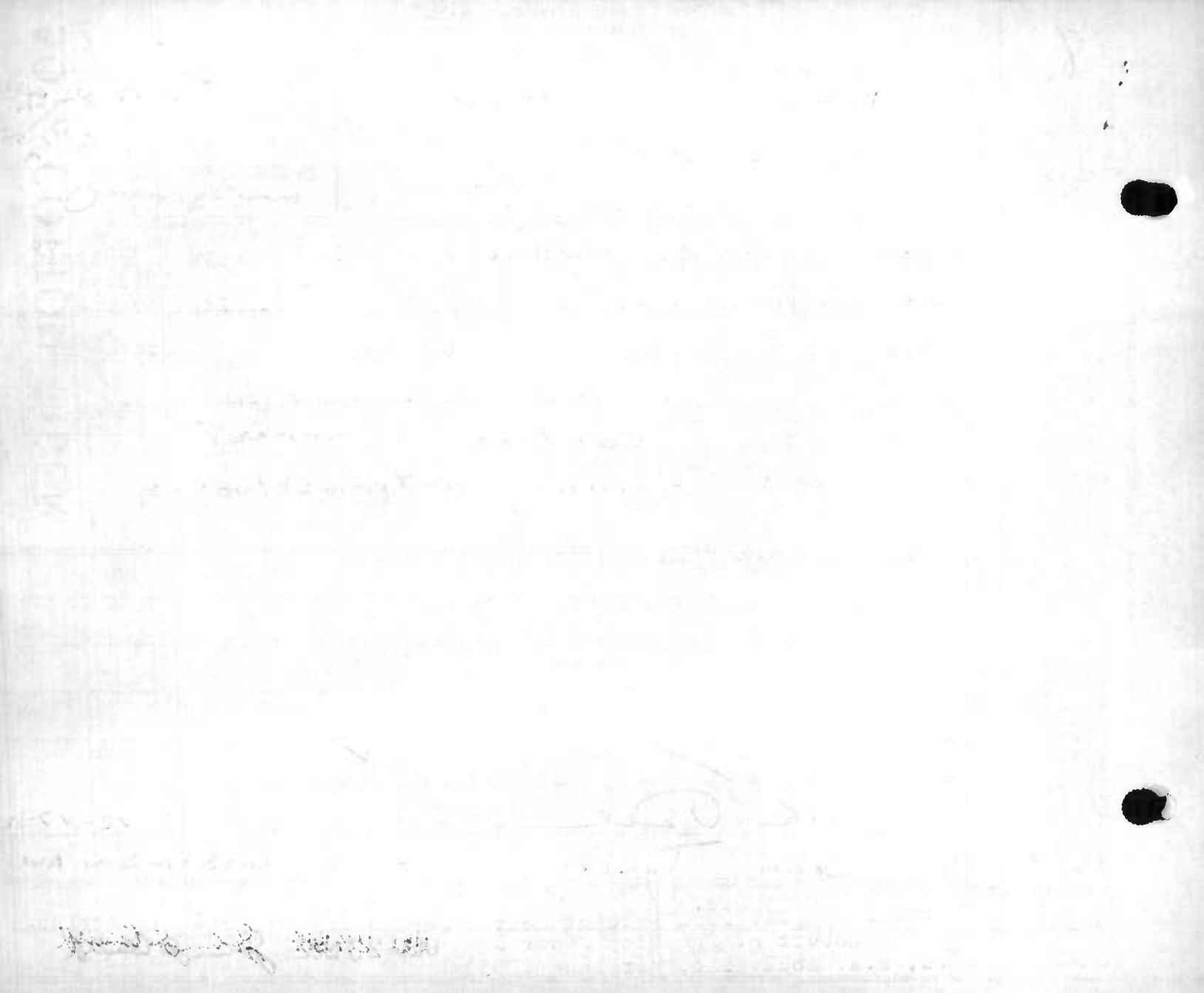
[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 32778 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) Peter Thomas Stathes | | | | | | | | | | 2b. DATE KNOWN OF DEATH ESTIMATED 12-17-82 | |
| 3. SEX Male | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 12-17-82 | |
| 4. RACE Cauc. | | | | | | | | | | 2d. DATE PRONOUNCED DEAD 12-17-82 | |
| 5. DATE OF BIRTH Sept. 30, 1916 | | | | | | | | | | 2e. DATE PRONOUNCED DEAD 12-17-82 | |
| 6. AGE (IN YEARS) 67 | | | | | | | | | | 2f. DATE PRONOUNCED DEAD 12-17-82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece | | | | | | | | | | 2g. DATE PRONOUNCED DEAD 12-17-82 | |
| 7b. CITIZEN OF WHAT COUNTRY? United States | | | | | | | | | | 2h. DATE PRONOUNCED DEAD 12-17-82 | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 2i. DATE PRONOUNCED DEAD 12-17-82 | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | | | | | | | | | 2j. DATE PRONOUNCED DEAD 12-17-82 | |
| 10. CITY OR TOWN OF DEATH Rockville | | | | | | | | | | 2k. DATE PRONOUNCED DEAD 12-17-82 | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp. | | | | | | | | | | 2l. DATE PRONOUNCED DEAD 12-17-82 | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed | | | | | | | | | | 2m. DATE PRONOUNCED DEAD 12-17-82 | |
| 12b. KIND OF BUSINESS OR INDUSTRY Equipment Leasing | | | | | | | | | | 2n. DATE PRONOUNCED DEAD 12-17-82 | |
| 13a. STATE Maryland | | | | | | | | | | 2o. DATE PRONOUNCED DEAD 12-17-82 | |
| 13b. CITY OR TOWN Montgomery | | | | | | | | | | 2p. DATE PRONOUNCED DEAD 12-17-82 | |
| 13c. CITY OR TOWN Potomac | | | | | | | | | | 2q. DATE PRONOUNCED DEAD 12-17-82 | |
| 14. FATHER'S NAME Thomas Stathes | | | | | | | | | | 2r. DATE PRONOUNCED DEAD 12-17-82 | |
| 15. MOTHER'S MAIDEN NAME Katherine Karambelas | | | | | | | | | | 2s. DATE PRONOUNCED DEAD 12-17-82 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | | | | | 2t. DATE PRONOUNCED DEAD 12-17-82 | |
| 16b. SOCIAL SECURITY NO. 326-01-3550 | | | | | | | | | | 2u. DATE PRONOUNCED DEAD 12-17-82 | |
| 17. INFORMANT Vera P. Stathes, same as #13 | | | | | | | | | | 2v. DATE PRONOUNCED DEAD 12-17-82 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John Paul TITLE (SPECIFY) M.D. MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 12-17-82 | |
| EXAMINER'S NAME (TYPE OR PRINT) John Paul ADDRESS 8218 Wisconsin Ave | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE Dec 21, 1982 | |
| 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850 | | | | | | | | | | 25. DATE REC'D BY REGISTRAR DEC 23 1982 REGISTRAR'S SIGNATURE John J. Lauer | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 3 2 7 7 9 | |
|---|--|--|---|---|---|--|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
MARILYN RAE STERN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 17 1982 | | | 2b. HOUR
10 42 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
3 19 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Missouri | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
TAROMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Adm. Asst. | | 12b. KIND OF BUSINESS OR INDUSTRY
US Govt. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS?
Md. Mont. Silver Spring <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET ADDRESS
401 Mansfield Road | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Lloyn Alvin Stafford | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Alice Belle Franciso | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | 16b. SOCIAL SECURITY NO.
579-40-4110 | | 17. INFORMANT ADDRESS
Same as Above
Charles G. Stern, Husband, | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
b) <u>Metastatic Lung Cancer</u>
c) <u>5 months</u>
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>27 Sept</u> 19 <u>82</u> to <u>17 Dec</u> 19 <u>82</u> , that (2) <u>last</u> <u>deceased</u> <u>17 Dec</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated (we) <u>did</u> <u>not</u> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Thomas A. Berkman</u> MD | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/18/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas A. Berkman MD | | | 22e. ADDRESS
7676 North Hampshire Ave Langley Park MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Rockville, Mont. 20783 | | | | |
| 24. FUNERAL DIRECTOR NAME
Robt E Wilhelm
Funeral Home | | | | | ADDRESS
4308 Suitland Rd., Suitland, Md. | | 25a. DATE RECD. BY REGISTRAR
DEC 27 1982 | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>John J. Connel</u> | | | | | | | | | | | |

MEDICAL CERTIFICATION

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Memorandum

For the Director

1944

Subject: [Illegible]

Very truly yours,
[Illegible Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 3 2 7 8 0 | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) LAURA W. STEVENS | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/1/82 | | 2b. HOUR
5 P.M. | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 13 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENN. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
OLNEY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHARON NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
H. WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | | | |
| 13a. STATE
MD. | | 13b. CITY OR TOWN
20904 MONT. | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2505 Seibel Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David T. Williams | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna - Markwick | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
209-36-0282 | | 17. INFORMANT
ADDRESS
JANET HAZZARD Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5850
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) Uremia | | | | | | | | | | 18b. SPECIFIC CAUSE OF DEATH
Uremia
1 yr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1/82 to 12/1/82 , that (I) (we) saw the deceased alive on 12/1/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
PH.D. | | | | 22c. DATE SIGNED
12/1/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
P. H. L. [Signature] | | | | 22e. ADDRESS
1811 P. P. Philip Dr Olney MD 20932 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC. 4, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
DUNMORE | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
DUNMORE, LACKAWANNA PENN. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANK H. BARBER | | | | ADDRESS
20879 POBOX 998 LAYTONSVILLE, MD. | | 25a. DATE REC'D. BY REGISTRAR
DEC 6 1982 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please see page 3 of the instructions for more details.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 8 1

| | | | |
|---|--|---|--|
| FOR
STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LILLIAN M STINE | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 18, 1982 | |
| 3. SEX
F | | 2b. HOUR
2:20 pm | |
| 4. RACE
CAUC. | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
JAN. 6 1900 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENN. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LEGAL SEC. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 12b. KIND OF BUSINESS OR INDUSTRY
RETIRED | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SLIGO GARDENS NURSING HOME | | 13a. STREET ADDRESS
8308 FLOWER AVE. 20012 | |
| 13a. STATE
MARYLAND | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13c. CITY OR TOWN
PRI. GEO'S TAKOMA PARK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELIZABETH ENGELDER | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY BLEICH | | 17. INFORMANT
NAME ADDRESS
SON 10217 RIDGEMOOR DR.
HARRY E. STINE SIL. SPG. MD. 20901 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
578-32-6930 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4360 Cerebrovascular accident
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1970 , 19 12-18-82 , to 1982 , that (I) (we) lost
saw the deceased alive on 12-8-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
M SNOW MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M SNOW MD | | 22e. ADDRESS
9013 FLOWER AVE SILVER SPRING MD 20901 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
DEC. 19, 1982 | |
| 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATION | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA VA. | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 25. DATE REC'D BY REGISTRAR
DEC 27 1982 | |

24. FUNERAL DIRECTOR

NAME
FRANCIS J. COLLINS

500 UNIV. BLVD. W.
SIL. SPG. MD. 20901

25. DATE REC'D BY REGISTRAR

DEC 27 1982

26. SIGNATURE OF REGISTRAR

John J. Connelley

NY 55-2

DECEMBER 11, 1962

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
SARAH LOU STITH | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 6 1982 | | 2b. HOUR
3:15pm | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 24 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
FLORIDA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL, NAVAL MEDICAL CMD | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BOOKKEEPING | | 12b. KIND OF BUSINESS OR INDUSTRY
SERVICE STATION | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE COUNTY
VIRGINIA FLOYD | | | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS
ROUTE 1 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES GLENN WINDHAM | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SADIE MAE SNELL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
233-26-4217 | | 17. INFORMANT ADDRESS
JAMES RUSSELL STITH ROUTE 1
FLOYD, VIRGINIA | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEIZURE
4960
DUE TO, OR AS A CONSEQUENCE OF
(b) COMPLICATING CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1 SEPTEMBER 19 82 to 6 DECEMBER 19 82, that (I) (we) last saw the deceased alive on 6 DECEMBER 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
B. CHERNOW | | | | 22c. DATE SIGNED
7 DEC 1982 | | | | 22d. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
Dec 7 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Md. Prince Geo. | | | |
| 24. FUNERAL DIRECTOR
w.w. Chambers CO | | | | 25a. DATE REC'D. BY REGISTRAR
8655 Georgia Ave
Silver Spring | | 25b. DATE REC'D. BY REGISTRAR
DEC 10 1982 | | | |

BP



Handwritten text, possibly a signature or initials, oriented vertically in the center-right area of the page.



Handwritten text at the bottom of the page, possibly a signature or a note, oriented horizontally.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete information has been furnished to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. STATE REGISTRAR | | 8 2 3 2 7 8 3
REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR | | 2b. HOUR
4:57pm | |
| Woodrow | | F. | | Strong | | | | 12/26/82 | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 yrs | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | | | MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital ER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BUTCHER | | 12b. KIND OF BUSINESS OR INDUSTRY
LOCAL 555 | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1708 Hampshire Green Lane | | 20902 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT F. STRONG | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
OLA BELLE WEEKS | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 11 | | 17. INFORMANT
son, Robert Strong | | 10316 JALWOOD AVE, S71 SPG, MD, 20902 | | Phone 301-649-4952 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>over 10 yrs.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
4100 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immed. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.
None. | | | | | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>Dec 26</u> , 19 <u>82</u> , that (I) (we) lost
saw the deceased alive on <u>12/26</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>William F. Simpson</u> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/26/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William F. Simpson MD | | 22e. ADDRESS
8106 N H Ave, Silver, Spring, Md 20903 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
DEC. 28, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA ALEXANDRIA VA | | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 500 UNIVERSITY BLVD. W. SILVER SPRING MD 20901 | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Smith</u> | | | | | |

BP

GERMANY DEC. 28, 1982 METROPOLITAN
FRANCIS J. COLLINS
300 UNIVERSITY BLVD. N. ST. LOUIS MO. 63101

ALEXANDRIA ALEXANDRIA ALEXANDRIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

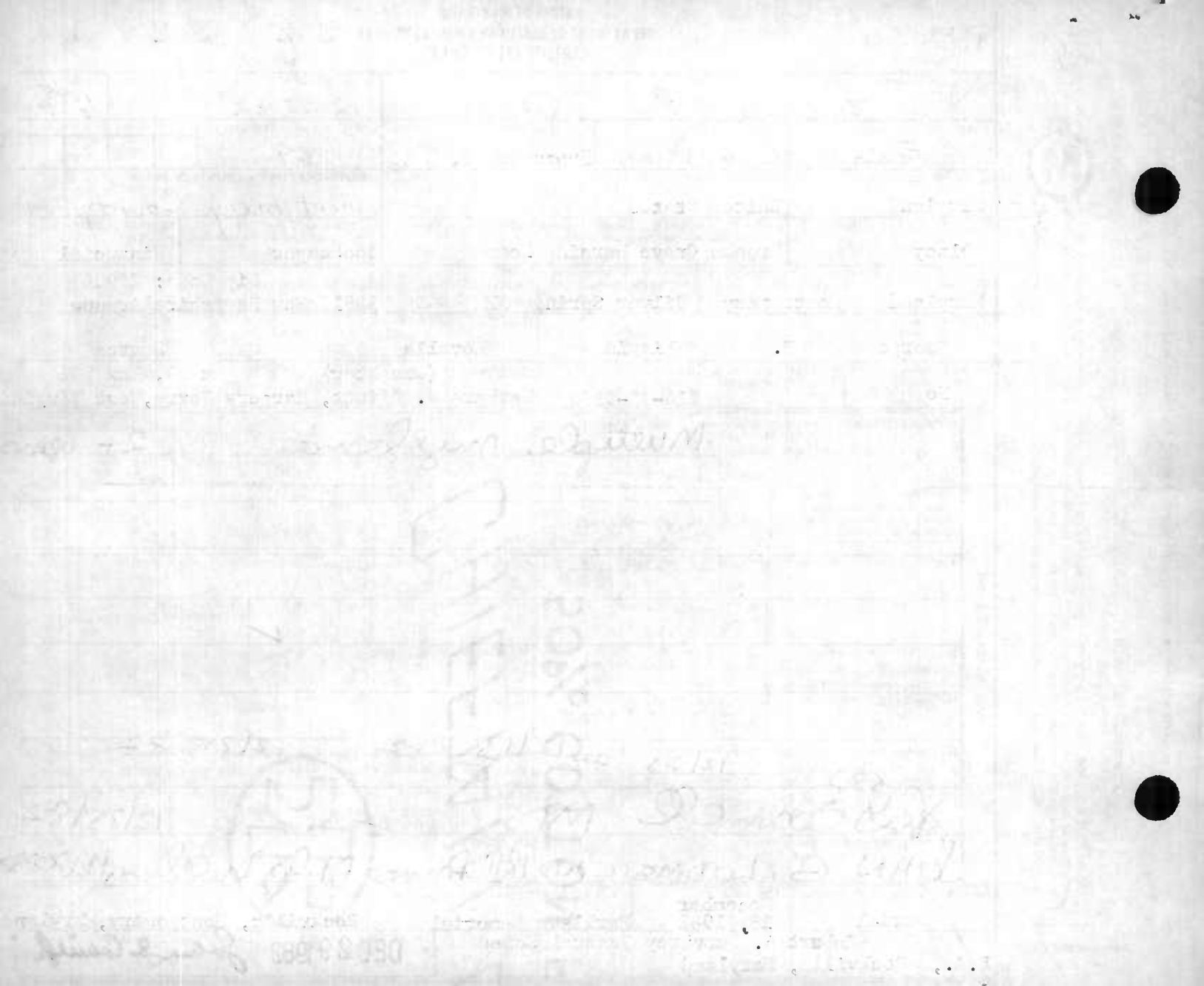
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 3 2 7 8 4 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Thelma R. Stubbs</i> | | | | 2a. DATE OF DEATH
MONTH DAY YEAR <i>12-25-82</i> | | | |
| 3. SEX
<i>Female</i> | | | | 2b. HOUR
<i>6:45 P.M.</i> | | | |
| 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>September 2, 1913</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>69</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County MD.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Bookkeeper</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>Olney</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Financial</i> | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Brooke Grove Nursing Home</i> | | | | 13a. STREET ADDRESS Zip Code: 20904
<i>13915 New Hampshire Avenue</i> | | | |
| 13a. STATE
<i>Maryland</i> | | | | 13b. COUNTY
<i>Montgomery</i> | | | |
| 13c. CITY OR TOWN
<i>Silver Spring</i> | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>George P. Riffin</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Lovella Swarts</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | | | | 16b. SOCIAL SECURITY NO.
<i>214-32-9390</i> | | | |
| 17. INFORMANT (Daughter) ADDRESS
<i>Rt #3, Box 886
Barbara S. Offutt, Harpers Ferry, West Virginia</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<i>2030 IMMEDIATE CAUSE (a) Multiple myeloma</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2+ years</i> | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/13/82</i> to <i>12/25/82</i> , that (I) (we) last saw the deceased alive on <i>12/25/82</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.) | | | | | | | |
| 22b. SIGNATURE
<i>JOAN G. LODMELL MD</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12/25/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>JOAN G. LODMELL MD</i> | | | | 22e. ADDRESS
<i>1811 Prince Philip Dr Olney Md 20832</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | | | 23b. DATE
<i>December 28, 1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parklawn Memorial</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Rockville, Montgomery, Maryland</i> | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Robert A. Pumphrey</i> | | | | ADDRESS
<i>Federal Homes P.A., Rockville, Maryland</i> | | 25a. DATE RECEIVED BY REGISTRAR
<i>DEC 29 1982</i> | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Givish</i> | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 8 5
REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Marie Sullivan | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12- 31- 82 | | | 2b. HOUR
6:15 A.M. | |
| 3. SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 - 3 - 1882 | | 6. AGE (IN YEARS LAST BIRTHDAY)
100
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SAN FRAN, CALIF | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring, MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sylvan Manor Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | |
| 13a. USUAL RESIDENCE (IF NOT IN SUCH HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Mont | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
Unknown | | 15. MOTHER'S MAIDEN NAME
Unknown | | 17. STREET ADDRESS
2700 Barker Ave. Silver Spring | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
323 05 8606 | | 17. INFORMANT
Registrow Office
James Cotton, St Elizabeth Hospital | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
5198 IMMEDIATE CAUSE (a) Respiratory Arrest | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Respiratory Infection | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from Dec. 29, 1977, to Dec. 31, 1982, that (I) (we) lost
saw the deceased alive on Dec. 20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|--|--|--|--|------------------------------|--|
| 22b. SIGNATURE
Christopher Unger | | DEGREE | | 22c. DATE SIGNED
12/31/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Christopher Unger, M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22e. ADDRESS
8218 Wisconsin Ave. Bethesda, MD 98694 | | | | | |

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Lees Cremator, D6 | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
4th & Mass Ave Wash DC | |
| 24. FUNERAL DIRECTOR
NAME
Duffy's Fun. Home | | ADDRESS
1425 Maryland Ave. Wash. DC. | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | |

BP.

1-20-1954

1-20-1954

1-20-1954
1-20-1954

1-20-1954

1-20-1954

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH OCCURRED AT HOME, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR BY MAIL. IF THE DEATH OCCURRED IN A HOSPITAL, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR BY MAIL. IF THE DEATH OCCURRED IN A NURSING HOME, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR BY MAIL. IF THE DEATH OCCURRED IN A HOSPITAL, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR BY MAIL. IF THE DEATH OCCURRED IN A NURSING HOME, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR BY MAIL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|------------------|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Max Taitz | | | 2a. DATE KNOWN OF DEATH
MONTH Dec DAY 24 YEAR 1982 HOUR 1:30 AM PM | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH
MONTH Mar DAY 2 YEAR 04 | 6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS. | IF UNDER 1 YR. MONTHS 0 DAY 0 HOUR 0 MIN. 0 | IF UNDER 24 HRS. MONTH 0 DAY 0 HOUR 0 MIN. 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lithuania | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | 10. CITY OR TOWN OF DEATH Pittsboro | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2915 Leisner World Blvd Apt 202 | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Cutter | | 12b. KIND OF BUSINESS OR INDUSTRY Clothing | |
| 13a. STATE MD | | 13b. COUNTY Mont | | 13c. CITY OR TOWN Pittsboro | |
| 14. FATHER'S NAME Charles | | 15. MOTHER'S MAIDEN NAME Rivka Kahn | | 16. SOCIAL SECURITY NO. 082 09 9287 z | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? No | | 17b. INFORMANT Jennie Taitz (same as #10) | | 17c. ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dist
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Chronic Myocardial Dist
DUE TO, OR AS A CONSEQUENCE OF
(c) None | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John P. Rogers M.D. | | TITLE (SPECIFY) Dep | | DATE Dec 24 1982 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 23a. LOCATION Elmont, New York COUNTY STATE | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE Dec. 23, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery | |
| 24. FUNERAL DIRECTOR NAME Ives Funeral Home | | 25a. DATE REC'D BY REGISTRAR DEC 28 1982 | | 25b. REGISTRAR'S SIGNATURE John P. Rogers | |

OPTIONAL FORM NO. 10

10-10-10

(121)
(W)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3 (SEE PAGE 5 FOR YOUR FILES). TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 3 2 7 8 7 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) John William Talbott | | | | | | | | | | 2a. DATE KNOWN OF DEATH Dec 28, 1982 | |
| 3. SEX M 4. RACE W 5. DATE OF BIRTH Sept 23 1942 6. AGE (IN YEARS) 40 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | | | | | | | | | 7b. HOUR 1:15 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | | | | | | | 2c. DATE PRONOUNCED DEAD Dec 28, 1982 7c. HOUR 1:15 M | |
| 10. CITY OR TOWN OF DEATH Olney 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. General Hosp 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER 12b. KIND OF BUSINESS OR INDUSTRY D.C. TRANSIT | | | | | | | | | | 12c. ADDRESS 20832 | |
| 13a. STATE MD 13b. COUNTY Mont. 13c. CITY OR TOWN Olney 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 3230 Spartan Rd | | | | | | | | | | 13f. ADDRESS 20832 | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) GEORGE W. TALBOTT 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) LAURA GATES | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) 579-01-6941 17. INFORMANT JOHN W. TALBOTT, JR. ADDRESS SAME AS 13 SON SON | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Chronic Myocardial
DUE TO, OR AS A CONSEQUENCE OF
(c) Xro. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Xro. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 19 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 19 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. TITLE (SPECIFY) Dep. MEDICAL EXAMINER DATE SIGNED Sept 28, 1982 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS ADDRESS 1919 SEMINARY RD., SILVER SPRING, MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 12/31/82 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901 25a. DATE REC'D. BY REGISTRAR JAN 6 1983 25b. REGISTRAR'S SIGNATURE John J. Collins | | | | | | | | | | | |

BP

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the application for a patent for the invention of a new and improved method of producing artificial silk from the silkworms of the genus Bombyx.
The application was received by the Commissioner of Patents on the 10th inst. and is now pending before the Patent Office.
I am, Sir, very respectfully,
Yours very truly,
J. H. H. H.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

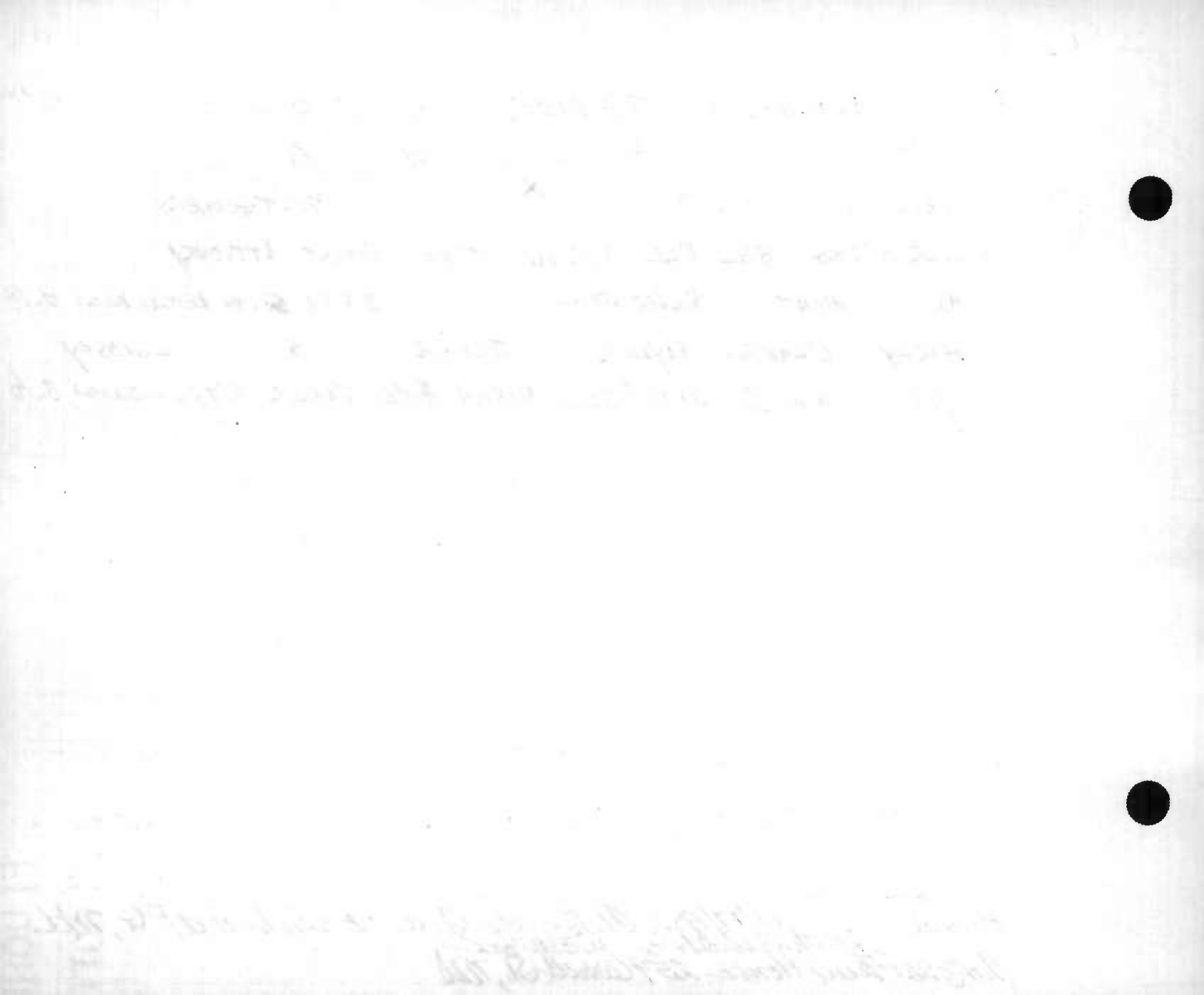
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 8 8

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|---|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
ALFRED L. TAYLOR | | | 2a DATE OF DEATH
MONTH DAY YEAR
15 Dec 82 | | | 2b HOUR
12:20 PM | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUG 6 1901 | | 6 AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10 CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BEL PRE NURSING HOME | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PATENT ATTORNEY | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | | 13b. CITY OR TOWN
MONT. | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
HARRY CLAYTON TAYLOR | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JENNIE S. LINDSAY | | | 13e. STREET ADDRESS
3373 SOUTH LEISURE WORLD BLVD | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N.W. II 577-05-2002 | | 17 INFORMANT
ADDRESS
MARION HINES TAYLOR, 3373 S. LEISURE WORLD BLVD | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4370 Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia + UTE
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Atherosclerosis + Dementia + multiple strokes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 19 76 , to 15 Dec 19 82 , that (I) (we) last saw the deceased alive on 9 Dec 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Gustavo S. Belaval, MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
15 Dec 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gustavo S. Belaval | | | | | | 22e. ADDRESS
Leisure World Medical Ctr Silver Spring Rd 20906 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12/17/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
H. Lincoln Gen. Burial Home | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Md. | | |
| 24. FUNERAL DIRECTOR
(NAME)
Garth W. Walters | | | | | | 25. DATE REC'D. BY REGISTRAR
DEC 20 1982 | | | |
| 26. REGISTRAR'S SIGNATURE
John J. Conish | | | | | | 27. REGISTRAR'S SIGNATURE
John J. Conish | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) John Boylan Thaler | | | | | 2a. DATE OF DEATH MONTH 12 DAY 12 YEAR 82 | | 2b. HOUR 8:35 PM | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 11 DAY 12 YEAR 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive Const | | 12b. KIND OF BUSINESS OR INDUSTRY computer | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 702 Kent Street 20850 | | | | | |
| 14. FATHER'S NAME FIRST John MIDDLE J. LAST Thaler | | | | 15. MOTHER'S MAIDEN NAME FIRST Florence MIDDLE Fryer LAST Fryer | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWII & Korea | | | | 16b. SOCIAL SECURITY NO. 055 16 3582 | | 17. INFORMANT ADDRESS Florence F. Thaler same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) congestive Heart Failure
4140
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours
Years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Irreversible Cerebral Cortical Damage due to Hypoxia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 19 19 82 , to Dec 12 19 82 , that (I) (we) lost saw the deceased alive on Dec 12 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Herman B. Segal MD | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22f. DATE SIGNED 12/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herman B. Segal MD | | | | 22e. ADDRESS 5639 Shields Drive Bethesda Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | | 23d. LOCATION CITY OR TOWN Arlington COUNTY Virginia STATE | | |
| 24. FUNERAL DIRECTOR'S NAME Tyson Wheeler | | | | 24b. ADDRESS Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852 | | | 25a. DATE REC'D. BY REGISTRAR DEC 17 1982 25b. REGISTRAR'S SIGNATURE John J. Carver | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 9 0

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EUGENE EDWARD THIES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 26, 1982 | | 2b. HOUR
1022 AM |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV 13 1919 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
63 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WISCONSIN | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY, BETHESDA MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA, MD. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL, BETHESDA | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED USN | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
VIRGINIA | | 13b. COUNTY
FAIRFAX | 13c. CITY OR TOWN
MCLEAN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDWARD HENRY THIES | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH META GEHRKE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1942-1962 387-14-4212 | | 17. INFORMANT
ADDRESS
MARY ELAINE THIES 7204 VAN NESS CT. MCLEAN | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: 1029 IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE LUNG
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 17 Dec 82, 1982, to 26 DEC 1982, that (I) (we) lost
saw the deceased alive on 26 DEC 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
M.R. MCMILLAN LT. MC USNR | | 22c. ADDRESS
Bethesda, Maryland | | 22d. DATE SIGNED
26 Dec 82 | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
12-30-1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | | 24. FUNERAL DIRECTOR
Arlington Funeral Home-Arlington, Virginia | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1982 | |
| 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | | | |

MEDICAL CERTIFICATION

1 9

RECEIVED
FEB 10 1972
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250

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FEB 10 1972
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250

10-20-1972 Arlington National Cemetery

Arlington National Cemetery, Arlington, Virginia

Arlington, Virginia

20% COL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|------------------------------------|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 2. DECEASED NAME
(TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. DATE OF DEATH | | 7. HOUR | |
| | | Adam James Thomas | | Male | | Caucasian | | April 14, 1917 | | December 8, 1982 | | 1560 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. USUAL OCCUPATION | | 11. KIND OF BUSINESS OR INDUSTRY | | | |
| North Carolina | | United States | | | | Montgomery County, MD. | | Emergency Health Coordinator | | Public Health | | | |
| 12. CITY OR TOWN OF DEATH | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 14. USUAL RESIDENCE
(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 15. INSIDE CITY LIMITS? | | 16. STREET ADDRESS | | 17. MOTHER'S MAIDEN NAME | | | |
| Rockville | | Shady Grove Adventist Hospital | | Maryland, Montgomery County, Potomac | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 11915 Reynolds Avenue (20854) | | Lessie Sasser | | | |
| 18. FATHER'S NAME
(FIRST MIDDLE LAST) | | 19. MOTHER'S MAIDEN NAME
(FIRST MIDDLE LAST) | | 20. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 21. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OF DATES) | | 22. INFORMANT
ADDRESS | | 23. DATE OF OPERATION | | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| George Sylvester Thomas | | Lessie Sasser | | Yes | | 244-10-0609 | | Constance B. Thomas, same as #13 | | 1982 | | 25. DATE OF OPERATION | |
| 26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 27. DEATH WAS CAUSED BY: | | 28. IMMEDIATE CAUSE (a) | | 29. DUE TO, OR AS A CONSEQUENCE OF | | 30. DUE TO, OR AS A CONSEQUENCE OF | | 31. DUE TO, OR AS A CONSEQUENCE OF | | 32. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4100 | | Cardiac arrest | | | | Myocardial infarction | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| 33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 34. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 36. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 37. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 38. DATE SIGNED | | 39. DATE SIGNED | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21e. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21f. DATE SIGNED | | 21g. DATE SIGNED | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21e. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21f. DATE SIGNED | | 21g. DATE SIGNED | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 23. SIGNATURE | | 24. PHYSICIAN'S NAME (TYPE OR PRINT) | | 25. ADDRESS | | 26. DATE SIGNED | | 27. DATE SIGNED | | 28. DATE SIGNED | |
| 1982 | | William H. Silverman MD | | William Silverman, M.D. | | 6111 Executive Blvd., Rockville, MD. 20852 | | Dec. 8, 1982 | | Dec. 8, 1982 | | Dec. 8, 1982 | |
| 29. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 30. DATE | | 31. NAME OF CEMETERY OR CREMATORY | | 32. LOCATION
CITY OR TOWN COUNTY STATE | | 33. DATE REC'D. BY REGISTRAR | | 34. REGISTRAR'S SIGNATURE | | 35. REGISTRAR'S SIGNATURE | |
| Cremation | | Dec. 10, 1982 | | Metropolitan Crematory | | Alexandria, Virginia | | DEC 13 1982 | | J. J. Corbett | | J. J. Corbett | |
| 36. FUNERAL DIRECTOR
NAME | | 37. DATE | | 38. NAME OF CEMETERY OR CREMATORY | | 39. LOCATION
CITY OR TOWN COUNTY STATE | | 40. DATE REC'D. BY REGISTRAR | | 41. REGISTRAR'S SIGNATURE | | 42. REGISTRAR'S SIGNATURE | |
| Robert A. Pumphrey Funeral Homes, PA | | Dec. 10, 1982 | | Metropolitan Crematory | | Alexandria, Virginia | | DEC 13 1982 | | J. J. Corbett | | J. J. Corbett | |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 3 2 7 9 2 | | | |
|--|--|-------------------------|--|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Clifford W. Thompson</i> | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED
<i>Dec. 12, 1982</i> | | 2b. HOUR
<i>1:18</i> | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH (MONTH DAY YEAR)
<i>MAY 17, 1912</i> | | 6. AGE (LAST BIRTHDAY) YRS.
<i>70</i> | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
<i>Dec. 12, 1982</i> | | 7d. HOUR
<i>1:18</i> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Virginia</i> | | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery MD</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>S. T. Spg.</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hosp</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Meter Repair</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Gas. Co.</i> | | | |
| USUAL RESIDENCE (IF NOT IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | |
| 13a. STATE
<i>MD</i> | | | | 13b. COUNTY
<i>Mont</i> | | | | 13c. CITY OR TOWN
<i>S. T. Spg.</i> | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<i>2808 Beechbank Rd</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>William A. Thompson</i> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Virgie M. Belt</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>yes WWII</i> | | | | 16b. SOCIAL SECURITY NO.
<i>579-03-2539</i> | | | | 17. INFORMANT ADDRESS
<i>Mary E. Thompson Same as #13</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
<i>4291</i> IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <i>Chronic Myocardial Dis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Yrs</i> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<i>None</i> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | | TITLE (SPECIFY)
<i>M.D.</i> | | | | MEDICAL EXAMINER
<i>Reg.</i> | | | | DATE SIGNED
<i>Dec. 12, 1982</i> | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
<i>DR. JOHN S. ROGERS</i> | | | | ADDRESS
<i>SILVER SPRING, MD.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | | | 23b. DATE
<i>Dec. 15, 1982</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Forest Oak</i> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Gaithersburg Mont. Md.</i> | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
<i>FRANCIS H. BARBER LAYTONSVILLE, MD. 20879</i> | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 15 1982</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Canfield</i> | | | | | |



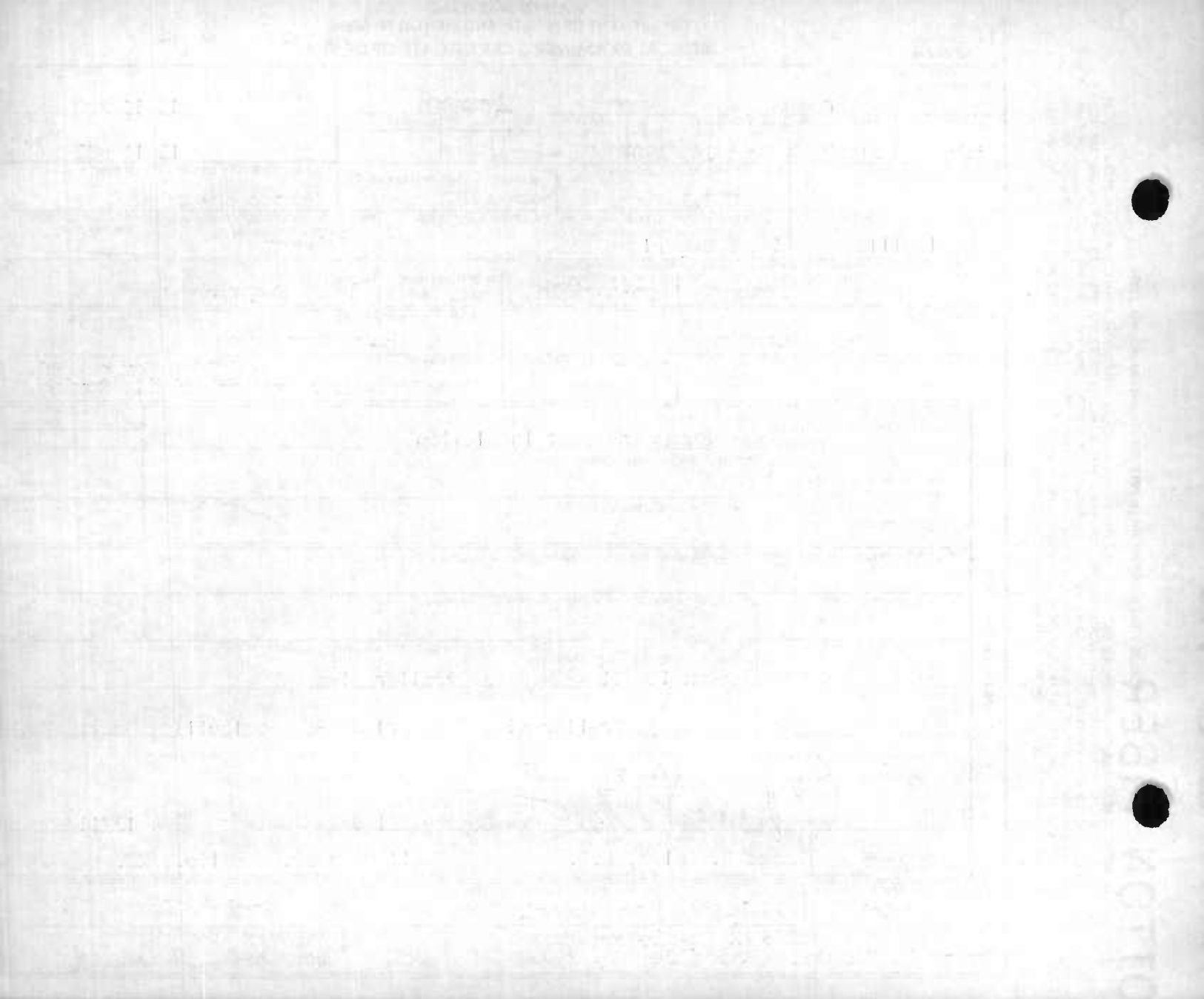
LIBRARY
MUSEUM



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 3 2 7 9 3 | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
Preston Hyson Thornton | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
12 11 1982 | | 7b. HOUR
M
4:49 | | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 14, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 11 1982 | | 2d. HOUR
M
4:49 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Pooleville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
14755 Sugarland Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Poolesville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
14755 Sugarland Road | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard Thornton | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Etta Hyson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Unknown | | 17. INFORMANT ADDRESS
Mary Etta Thornton (Mother) Sil. Spring, Md. 2940 Norbeck Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Smoke and soot inhalation
8902
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
3:44 PM 12 11 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
House trailer fire | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
house trailer | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
14755 Sugarland Rd, Pooleville, Mont., Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Thomas D. Smith, M.D. | | | | TITLE (SPECIFY)
M.D. Deputy Chief Medical Examiner | | | | DATE SIGNED
12/11/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS
111 Penn St. Balto., MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-16-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Ash Memorial Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sandy Spring, Montg. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME
George R. Snowden | | | | | | 246 N. Washington Street
Rockville, Md. 20850 | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1982 | | | | 25b. REGISTRAR'S SIGNATURE
John J. Canine | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|---|--|---|---|---|---|---|---|--|
| 1- FOR STATE REGISTRAR | | | | | 8 2 3 2 7 9 4 | | | | | |
| CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
FLORA E. TILLSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 19 82 | | | | | 2b. HOUR
3¹⁰ P |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 15 1906 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
76 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS. | | 8. IF UNDER 74 HRS.
HOURS MIN.
MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Switchbrd. Oper. | | 12b. KIND OF BUSINESS OR INDUSTRY
Riggs Nat'l. Bank | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Montgomery Kensington | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10228 Day Avenue 20895 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles S. Anderson | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Flora E. Haynes | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | 16b. SOCIAL SECURITY NO.
578-22-7539 | | 17. INFORMANT
ADDRESS
Donald E. Tillson Rockville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ruptured left ventricle
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) acute myocardial infarct
DUE TO, OR AS A CONSEQUENCE OF
(c) atherosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours
1 day | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (he (this hospital) attended the deceased from 12/18 , 19 82 , to 12/19 , 19 82 , that (he (we) lost saw the deceased alive on 12/19 , 19 82 and that in (my (our) opinion death occurred on the date and hour and from the causes stated above. (If (yes) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Paul T. Werzlake MD
DEGREE
MD | | | | | 22c. DATE SIGNED
12/20/82 | | | 22d. ADDRESS
SUBURBAN Hospital
8600 OLD GEORGETOWN RD, BETHESDA, MD | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | | 23b. DATE
12/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
Suitland, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Warner E. Pumphrey, Inc. Sil. Spr., Md. | | | | | 25. DATE REC'D. BY REGISTRAR
DEC 23 1982 | | 25. REGISTRAR'S SIGNATURE
John J. Canfield | | | |

BP

2 days
1 day

happy life with the
best of people in the
world

X X

1917

1917

1917

1917

1917

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH OCCURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 2 3 2 7 9 5 | |
|---|--|-------------------------------|--|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) George R. Titus | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12 DAY 26 YEAR 1982 | | | | 2b. HOUR 12:15 | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 12-17-02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 12-26-1982 | | 2d. HOUR 12:15 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Advertising | | | | 12b. KIND OF BUSINESS OR INDUSTRY WTOP | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5101 RIDGE FIELD RD | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William S. Titus | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy Halliday Warren | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | 16b. SOCIAL SECURITY NO. 578-09-9383 | | 17. INFORMANT ADDRESS Roger W Titus. 4200 Oakridge Lane, Chevy Chase, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) CORONARY ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) YKS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY 11:25 P.M. 12 25 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED ON FLOOR | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5101 RIDGEFIELD RD BETHESDA MONT. MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion. | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C Mayle | | | | | | TITLE (SPECIFY) DEPT M.D. | | MEDICAL EXAMINER | | DATE SIGNED 12/26/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE | | | | | | ADDRESS 8200 Wisconsin Ave Bethesda MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12/28/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bealsville Maryland. | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. NAME ADDRESS 5130 Wisc. Ave., N.W. Wash., D. C. | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Grier | | | | | |

also

XX

New York

U.S.A.

1944-1945

1944-1945

William

John

John

William

William

to

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 3 2 7 9 6
CERTIFICATE OF DEATH

| | | | |
|--|--|---|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
Pauline B Toomey | | 2a. DATE OF DEATH MONTH DAY YEAR
12-12-82 | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
6 16 1895 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. AGE (IN YEARS LAST BIRTHDAY)
87 | 9. UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YES |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | 12. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13c. COUNTY
Montgomery | | 13d. CITY OR TOWN
Rockville | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Robert Bovis | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unknown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
578-52-0243 | |
| 17. INFORMANT
Joseph A. Toomey | | ADDRESS
5003 Rayburn Ct. Rockville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1629 Pulmonary Edema
IMMEDIATE CAUSE (a) 3 days
DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma - lung
1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| MEDICAL CERTIFICATION | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. AUTOPSY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
12 12 1982 | |
| 21c. INJURY OCCURRED | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21 OR PART 3) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
12/12/82 | |
| 22a. I certify that (a) (this hospital) attended the deceased from 12/12/82 to 12/12/82 that (b) (we) last saw the deceased alive on 12/12/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (if I (we) did not view the body after death) | | | |
| 22b. SIGNATURE
Thos G. Ward | | 22c. DATE SIGNED
12/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. Ward | | 22e. ADDRESS
616 Robinsons Bethesda 20817 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/15/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Brentwood, Maryland | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 25. DATE REC'D. BY REGISTRAR
DEC 16 1982 | |

Handwritten text, mostly illegible due to fading and bleed-through. The text appears to be organized into sections, possibly a list or a series of entries. Some legible fragments include:

- Top left: "1911"
- Top center: "F. W. L. 5"
- Top right: "1911"
- Middle left: "1911"
- Middle center: "1911"
- Middle right: "1911"
- Bottom left: "1911"
- Bottom center: "1911"
- Bottom right: "1911"

The text is written in a cursive or semi-cursive script. There are several large, dark, circular marks on the right side of the page, which appear to be punch holes or large ink smudges.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | REG. NO. 8 2 3 2 7 9 7 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Joseph I Touchette | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-12-82 | | | 2b. HOUR
12:31 A.M. | |
| 3. SEX
MALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
05-13-96 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Connecticut | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FERNWOOD HOUSE | | | | 12a. USUAL OCCUPATION (LAST OF WORKING LIFE)
Foreign Service Officer U.S. Gov't | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Eugene Touchette | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Louise Gervais | | 13e. STREET ADDRESS
8617 Irvington Ave. 20817 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WWI | | 17. INFORMANT ADDRESS
Denyse H. Touchette, Wife, #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4280 <i>Coronary Artery Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 yr</i>
<i>2 yr</i> | | | | | | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Mediastinal Lymphoma</i> |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-2</i> , 19 <i>82</i> , to <i>12-2</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>12-2</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>William H. Kelly M.D.</i> | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>Dec 14 82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William H. Kelly | | | | 22e. ADDRESS
8218 Wisconsin Ave Bethesda MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 15, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Silver Spring, MD | | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey | | | | Homes, P.A., Bethesda, Maryland | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Smith</i> | |

BP

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 01-08-2010 BY 60322

2021-2022

175

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CHIEFLY

20X COIN FL



BP _____
DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
FIRST MIDDLE LAST
FRANCES L TRAYLOR | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec 5 82 | | | | | 2b. HOUR
0647 M |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUG 30, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 8. IF UNDER 24 HRS
HOURS MIN.
00 00 |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
WESTERN RAILROAD | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
DERWOOD | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROY G. BEALL | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GRACE MIDDLETON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
578-14-4048 | | 17. INFORMANT
ADDRESS
CAROL J. SWARTZ SAME AS 13 GOD-DAUGHTER | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) Metastatic lung carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec 3 , 19 82 , to Dec 5 , 19 82 that (1) (we) last saw the deceased alive never 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) see the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Mark S Rosen | | | | | DEGREE
MD | | | 22c. DATE SIGNED
12/5/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark Rosen | | | | | 22e. ADDRESS
Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
12/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY
GLENWOOD CEMETERY | | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
WASHINGTON, D.C. | | | | |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS
NAME ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 - 1982 | | 25b. REGISTRAR'S SIGNATURE
Joan J. Connel | | | |

MEDICAL CERTIFICATION



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 7 9 9

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|---|---|--|-------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Celia G. Turrell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 22, 1982 | | 2b. HOUR
NOON | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 18, 1899 | | |
| 6. AGE [IN YEARS (LAST BIRTHDAY)]
83 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS. | | 8. IF UNDER 24 HRS.
HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Michigan | | 10. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 12. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | 13. CITY OR TOWN OF DEATH
Rockville | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
14004 Drake Drive | | |
| 15. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 16. KIND OF BUSINESS OR INDUSTRY | | 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
17a. STATE
Maryland
17b. COUNTY
Montgomery
17c. CITY OR TOWN
Rockville
17d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 18. STREET ADDRESS
14004 Drake Drive | | 19. Zip Code:
20906 | | 20. FATHER'S NAME
FIRST MIDDLE LAST
Alex M. Girardin | | |
| 21. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amelia Weitenberner | | 22. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 23. SOCIAL SECURITY NO.
371-46-7625 | | |
| 24. INFORMANT
Robert D. Heckle | | 25. ADDRESS
14004 Drake Drive, Rockville, Maryland 20906 | | 26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple cerebral thrombi
4340
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis
several weeks
several years
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease with Congestive Failure | | |
| 27. DATE OF OPERATION
12/20/82 | | 28. CONDITION FOR WHICH OPERATION WAS PERFORMED
CONGESTIVE FAILURE | | 29. AUTHORITY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 30. IF YES, WERE FINDINGS USED IN CERTAINING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 31. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 32. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
5/19/79 | | |
| 33. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 34. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 35. LOCATION
STREET CITY OR TOWN COUNTY STATE
5/19/79 | | |
| 36. I certify that (I) (this hospital) attended the deceased from above, the deceased alive on 12/20/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | 37. SIGNATURE
Michel M. Healy M.D. | | 38. DATE SIGNED
December 22, 1982 | | |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)
Michel M. Healy, M.D. | | 40. ADDRESS
5652 Shields Drive Bethesda, Maryland 20817 | | 41. DATE REC'D. BY REGISTRAR
DEC 27 1982 | | |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 43. DATE
December 24, 1982 | | 44. NAME OF CEMETERY OR CREMATORY
Mt Elliott Cemetery | | |
| 45. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland | | 46. ADDRESS
Rockville, Maryland | | 47. REGISTRAR'S SIGNATURE
John J. Conish | | |

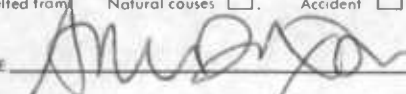



DEC 27 1985

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **8 2 3 2 8 0 0**

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|------------------------------|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) RAYMOND VAN GIESON | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-7/8 19 82 | | 2b. HOUR M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR 3 24 56 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 26 | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
932 Wayne Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Maintenance Man | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Takoma Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS
7106 Sycamore Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Merle VanGieson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elsie Ellis | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
ADDRESS
Merle VanGieson Montgomery, Vermont | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sharp force cranio-cerebral trauma
9682
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 12-7/8 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject struck on head. | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
bldg. | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
932 Wayne Ave., Silver Spring, Montgomery, Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 12-10-82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
12-13-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process, Inc. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Marzullo Funeral Service Reisterstown, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 14 1982 | | 25b. REGISTRAR'S SIGNATURE
 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 3 2 8 0 1 | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| CHERYL ANN VELASQUEZ | | | | DECEMBER 12 1982 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | | CAUCASIAN | | JULY 21 1954 | | 28 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MASSACHUSETTS | | UNITED STATES | | | | MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | | NAVAL HOSPITAL | | HOUSEWIFE | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | | | MONTGOMERY | | ROCKVILLE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| JAMES HENRY LOOMIS, JR | | | | MARILYN DORETHEA WILDER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | 028-46-6353 | | LUIS VELASQUEZ, 713 MONROE STREET, APT 102 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | ROCKVILLE, MD 20850 | | | |
| IMMEDIATE CAUSE (a) ENCEPHALITIS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 2790 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | (b) COMMON VARIABLE HYPOGAMMAGLOBULINEMIA | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 7 19 82 to DECEMBER 12 19 82, that (I) (we) lost saw the deceased alive on DECEMBER 12 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| H.L. REED, LT, MC, USNR | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 14 DEC 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| H.L. REED, LT, MC, USNR | | | | NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 12-17-82 | | SPRINGFIELD STREET CEM. FEEDING HILLS, MASSACHUSETTS | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| IVES FUNERAL HOME | | 2847 WILSON BLVD. ARLINGTON, VIRGINIA | | DEC 21 1982 | | John J. Cabell | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

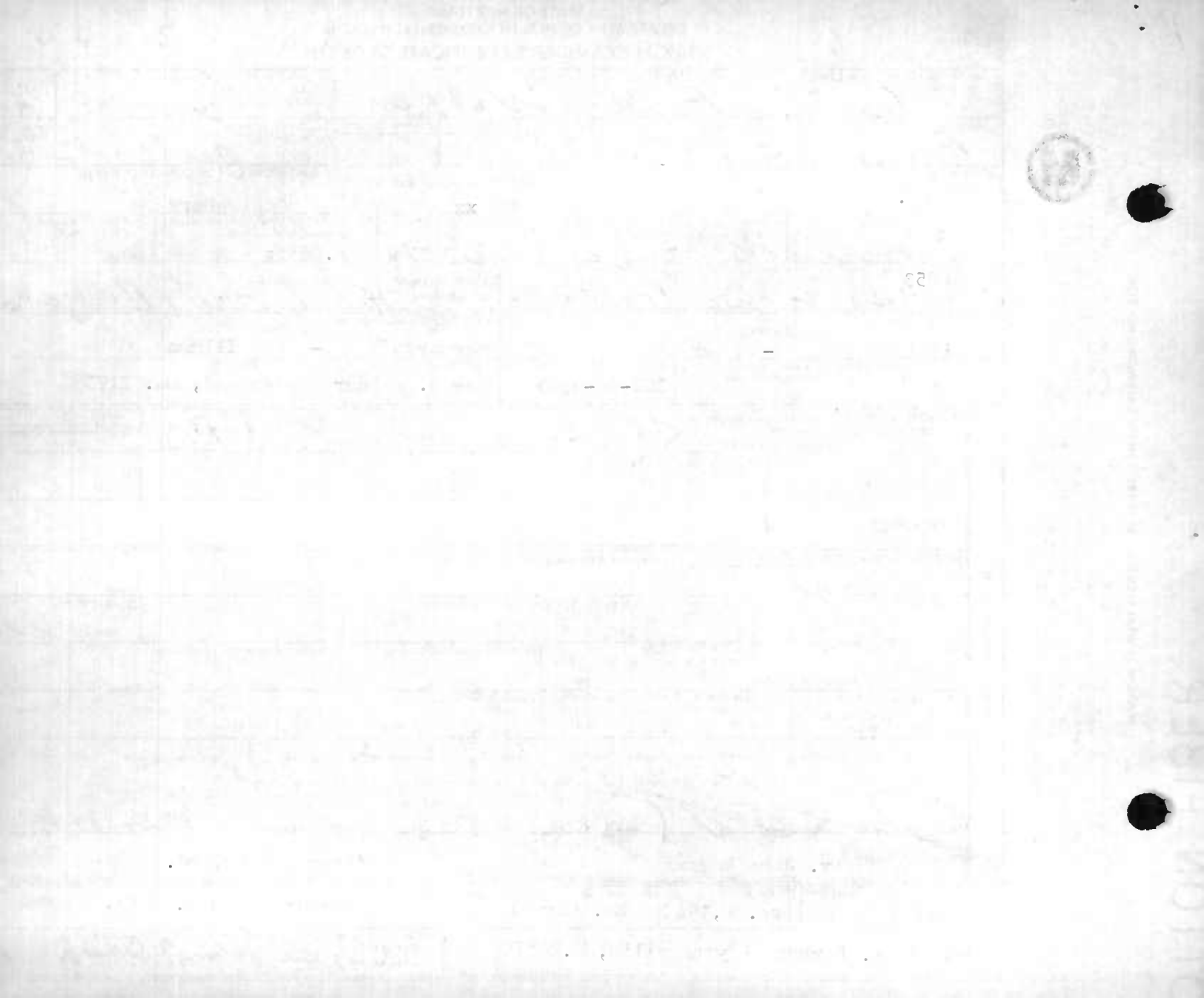
DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 3 2 8 0 2
REG. NO. | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ISABEL EWING WALKER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 11 1982 | | 2b. HOUR
4:45 P_M | |
| 3 SEX
FEMALE | | 4 RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
NOVEMBER 24 1904 | | 6 AGE (IN YEARS LAST BIRTHDAY)
78 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OHIO | | 7b CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE)
HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY
own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
VIRGINIA | | | | 13b CITY OR TOWN
FAIRFAX | | 13c STREET ADDRESS
6251 OLD DOMINION DRIVE 22101 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
THOMAS FENWICK EWING | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY GENIEVE WALSH | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
188-36-8873 | | 17 INFORMANT ADDRESS
JAMES P. WALKER, JR., 235 ENFIELD FALLS ROAD, | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
1419 IMMEDIATE CAUSE (a) CEREBRAL ANOXIA SECONDARY TO CARDIOPULMONARY ARREST AFTER SURGICAL RELEASE OF RIGHT TONGUE
DUE TO, OR AS A CONSEQUENCE OF
SQUAMOUS CELL CARCINOMA OF THE RIGHT TONGUE
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 5, 1982 to DECEMBER 11, 1982 , that (I) (we) last saw the deceased alive on DECEMBER 11, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>George J. Farrell</i> #10, LCDR, MC, USN | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE J. FARRELL, LCDR, MC, USN | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial/transit | | 23b. DATE
Dec. 15, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Agnes Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Forest City, Pennsylvania | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey | | | | 25. DATE REC'D. BY REGISTRAR
DEC 17 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Casper</i> | |
| P.A. Bethesda, Maryland | | | | | | | |

DEC 17 1985
J. G. Smith

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 3 2 8 0 3 | |
|--|----------------------|---|--|--|-----------------------------|--|--|--|--|------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILMA FREDA WALKER | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED Dec 13 1982 | | 2b. HOUR 10:00 AM | | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH (MONTH DAY YEAR) Aug. 3. 1945 | 6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD Dec 17. 1982 | | 2d. HOUR 10:00 AM | | | |
| 7a. BIRTHPLACE - (STATE OR FOREIGN COUNTRY) Penn. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. General Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. ST. 20853 | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4007 Holly Ridge Rd | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William - Brant | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret - Illman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 202-24-4943 | | 17. INFORMANT ADDRESS Zane G. Walker Glenwood, Md. 21738 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Inf
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Dr. John Rogers | | TITLE (SPECIFY) M.D. | | | | MEDICAL EXAMINER | | DATE SIGNED Dec 17, 1982 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS Silver Spring, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 20, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sunshine Mont. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Francis H. Barber ADDRESS Laytonsville, Md. 20879 | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 21 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Gough | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 8 0 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Iva H. Walsh | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-8-82 | | | 2b. HOUR
4:30 AM | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 8, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fernwood House | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
County Schools | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
20817
6611 Marywood Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Peter Huggler | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Parrett | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
216-44-6891 | | 17. INFORMANT
ADDRESS
711 Fordham Street
Mabel H. Black Rockville, Maryland | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

3019

IMMEDIATE CAUSE (a) Organic Brain Syndrome

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

Polymyagia Rheumatica / Temporal Arteritis

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16/82 to Present, 1981, to Present, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert H. Blee MD | | | | DEGREE | | 22c. DATE SIGNED
12/8/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert H. Blee | | | | 22e. ADDRESS
8218 Wisconsin Ave, Bethesda Md | | | |

| | | | | | | | |
|--|--|---------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Dec. 9, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral
Homes, P.A. Bethesda, Maryland 20814 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1982 | | 25b. REGISTRAR'S SIGNATURE
John J. Vignone | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5868.

BP _____



DHMH - 16 50M 4/B2
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 8 0 5

REG NO.

| | | | | | | | | | | |
|---|--|---|-------------|---|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
ROSE | MIDDLE
B | LAST
WALSH | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 4 1982 | | 2b. HOUR
40 a.m. | | | |
| 3. SEX
Female | | 4. RACE
caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 13 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MASSACHUSETTS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
HOMEMAKER | | |
| 13a. STATE
MARIAND | | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
KENSINGTON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
AGUSTUS T. RODGERS | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY JOSEPH MACHADA | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-03-1307 | | 17. INFORMANT
ADDRESS
JOSEPH I. WALSH SAME AS 13 HUSBAND | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4310
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial and intracerebral
DUE TO, OR AS A CONSEQUENCE OF (c) (Kerning) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 Hrs. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from December 1 1982 to December 4 1982, that (1) (we) last saw the deceased alive on December 3 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (do) (do not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Benjamin Franklin | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12-4-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Benjamin Franklin, M.D. | | | | | 22e. ADDRESS
3720 Fairview Ave. Ken. Md 20895 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY
CALVARY CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLOUCESTER ESSEX MASS. | | | | |
| 24. FUNERAL DIRECTOR
NAME
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 - 1982 | | 25b. REGISTRAR'S SIGNATURE
John J. Connelley | | | |



20% COLD

FIVE-X

RECEIVED 11/11/11

11/11

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11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP

DHMH - 16-50M 4/82
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 8 0 6

REG. NO.

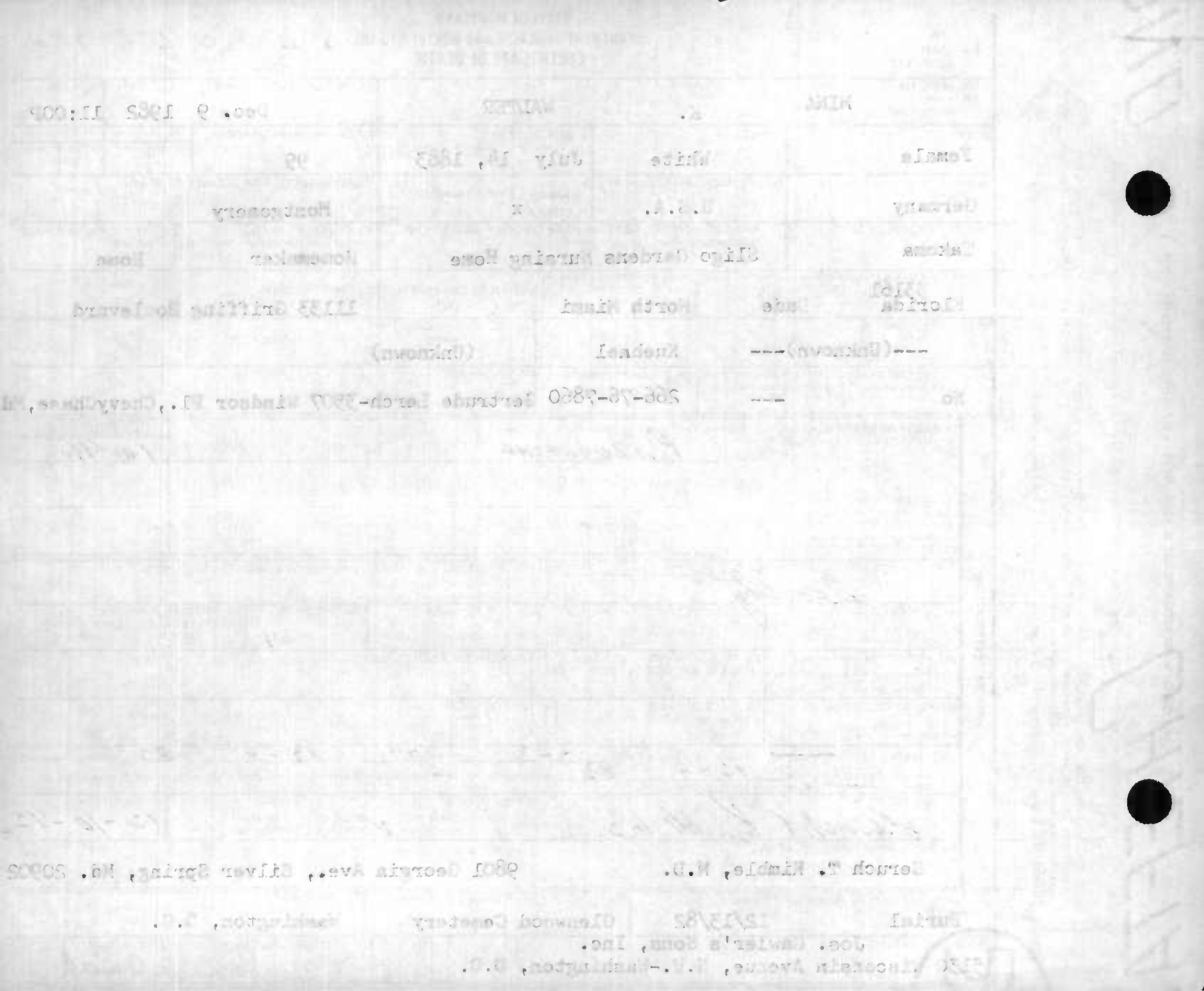
1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MINA K. WALTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 9 1982 | | | 2b. HOUR
11:00P | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 14, 1883 | | 6. AGE (IN YEARS LAST BIRTHDAY)
99 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sligo Gardens Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Florida | | 13b. COUNTY
Dade | | 13c. CITY OR TOWN
North Miami | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11133 Griffing Boulevard | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
--- (Unknown) --- Kuehnel | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(Unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT
ADDRESS
Gertrude Lerch-3507 Windsor Pl., Chevy Chase, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4860 IMMEDIATE CAUSE (a) Paludism
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 m. 16. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Seriously | | | | | | | | | |
| 19a. DATE OF OPERATION
12-9 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Seriously | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-3 , 19 77 , to 12-9 , 19 82 , that (I) (we) last saw the deceased alive on 12-4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Serach T. Kimble, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-10-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Serach T. Kimble, M.D. | | | | 22e. ADDRESS
9801 Georgia Ave., Silver Spring, Md. 20902 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
Burial | | 23b. DATE
12/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Glenwood Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Jos. Gawler's Sons, Inc.
5130 Wisconsin Avenue, N.W.-Washington, D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE
John J. Gawler | | | | | | | | | |

2/13/85
 Joe. Lawler's Sons, Inc.
 1700 Annapolis Avenue, N.W., Washington, D.C.

Washington, D.C.

Gertrude T. Kimble, N.D.
 9801 Georgia Ave., Silver Spring, Md. 20902



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 3 2 8 0 7 | |
|---|--|------------------------|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
CAROL HOME WARD | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12 29 1982 | |
| 3. SEX
F | | 4. RACE
CAUC | | 5. DATE OF BIRTH MONTH DAY YEAR
12 25 36 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
46 | | IF UNDER 1 YR. MONTHS DAYS | | 2c. DATE PRONOUNCED DEAD
12 29 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Consultant | | 12b. KIND OF BUSINESS OR INDUSTRY
Travel | |
| 13a. STATE
MD | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
20852 4709 ARBUTUS AVE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
George D. Miller | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Cecil H. Ledger | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
578 46 5245 | | 17. INFORMANT ADDRESS
Ralph S. Ward same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INCREASED INTRACRANIAL PRESSURE
8159
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) MULTIPLE TRAUMA
DUE TO, OR AS A CONSEQUENCE OF
(c) 24 hrs | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
— | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
3:00 P.M. 12 28 1982 | | | | 21b. TIME OF INJURY HOUR AM, MONTH DAY YEAR
3:00 P.M. 12 28 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
AUTO ACCIDENT SINGLE CAR | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
STREET | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
270 AT Democracy Rockville MONT. MD | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C. Mayle Jr | | | | TITLE (SPECIFY) Dept M.D. | | | | MEDICAL EXAMINER DATE SIGNED 12/29/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE JR | | | | ADDRESS 8700 Wisconsin Ave Bethesda MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
1/3/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR NAME
Tyson Wheeler Funeral Home, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 5 1983 REGISTRAR'S SIGNATURE John J. Canfield | | | | | |
| ADDRESS
1331 Rockville Pike Rockville, Md. 20852 | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

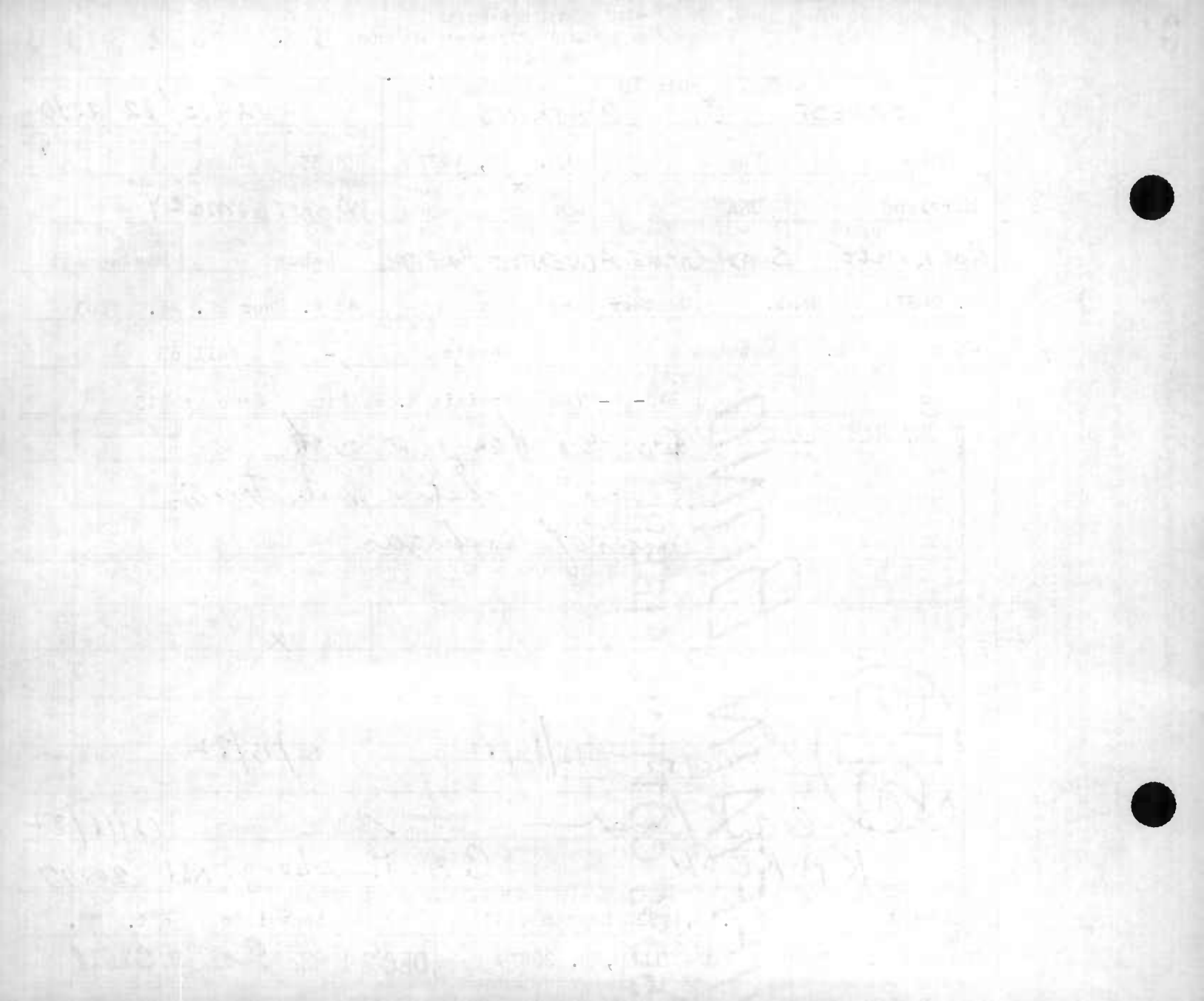
BP

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 3 2 8 0 8 | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ERNEST C. WATKINS | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/15/82 | | | | 2b. HOUR
2240 M | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUG. 18, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Labor | | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | | | | |
| 13a. STATE
Md. 20877 | | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
48 W. Deer Pk. Rd. #203 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John L. Watkins | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie - Wallach | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
218-20-0710 | | 17. INFORMANT
ADDRESS
Virginia M. Watkins Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1509
IMMEDIATE CAUSE (a) Cardio Resp. arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe Cachexia, malnutrition
DUE TO, OR AS A CONSEQUENCE OF
(c) Cancer of esophagus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1509 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/14/82 19____, to 12/15/82 19____, that (I) (we) lost saw the deceased alive on 14/5/82 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Charles K. Kover | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/16/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KAKESH | | | | | | 22e. ADDRESS
Gaithersburg, Md. 20877 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec. 18, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Laytonsville | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laytonsville Mont. Md. | | | | | |
| 24. FUNERAL DIRECTOR
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1982 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | | | |

MEDICAL CERTIFICATION

29



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in page.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 3 2 8 0 9 | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|--|--|
| FOR
1- STATE
REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) <i>Edith Estella Wehage</i> | | | | | | 2a DATE OF DEATH MONTH DAY YEAR
<i>December 21 1982</i> | | | | 2b HOUR
<i>10 AM</i> | | | |
| 3 SEX
<i>FEMALE</i> | | 4 RACE
<i>CAUCASIAN</i> | | 5 DATE OF BIRTH
MONTH DAY YEAR
<i>January 1, 1891</i> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<i>91</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Baltimore, Md.</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County, Md.</i> | | | | | | | |
| 10 CITY OR TOWN OF DEATH
<i>Rockville</i> | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>National Lutheran Home for the Aged</i> | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Salisbury</i> | | | 12b KIND OF BUSINESS OR INDUSTRY
<i>unknown</i> | | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
<i>Maryland Baltimore Co. Baltimore</i> | | | | | | 13b INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c STREET ADDRESS
<i>728 Edmundson Ave.</i> | | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
<i>George A. Pistol</i> | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Emma E. Boecker</i> | | | | Md. | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>216-03-3288</i> | | 17 INFORMANT ADDRESS
<i>Rev. Richard Reichard 9701 Veirs Dr. Rockville, Md.</i> | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<i>4140</i> IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
b) <i>arteriosclerotic Heart Disease 5 yrs</i>
DUE TO, OR AS A CONSEQUENCE OF
c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>Aug 10</i> 19 <i>78</i> to <i>Dec. 21</i> 19 <i>82</i> that (I) (we) last saw the deceased alive on <i>Dec. 20</i> 19 <i>82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Harold F. McCann</i> DEGREE
<i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
<i>12-21-82</i> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>HAROLD F. MCCANN</i> | | | | 22e ADDRESS
<i>3355-16th St. N.W. WASH. D.C. 20010</i> | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Dec. 24, 1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Druid Ridge Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore, Maryland</i> | | | | | | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
<i>The Hysong Company 1300 N St. N.W. Wash. D.C.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 7 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Jan L. Carver</i> | | | | | | | |

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Page 1** of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, **Page 2** should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8 2 3 2 8 1 0
REG. NO. | | | | | | |
|--|--|--|--|---|---|--|---|--|---------------------|-------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Gladys Virginia Weiford | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 13 1982 | | | | 2b. HOUR 4 M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 28, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6104 Welborn Drive | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6104 Welborn Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel B. Gary | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosa Mae Neal | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
225-10-7717 | | 17. INFORMANT ADDRESS
Leonard D. Weiford-Address same as #13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Esophagus
1509 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19 57 to Dec. 13 19 82 that (I) (we) last saw the deceased alive on Dec. 13 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Joseph J. Wallace M.D. | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph J. Wallace, M.D. | | | | | | 22e. ADDRESS
5272 River Road, Bethesda, Md. 20816 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
12/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Jos. Gawler's Sons, Inc.
5130 Wisconsin Avenue, N.W.-Washington, D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1982 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | |

UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

| County | State | Area | Population | Production |
|--------|--------|-------|------------|------------|
| Adams | Ill. | 1,200 | 100,000 | Wheat |
| Adair | Iowa | 1,200 | 100,000 | Wheat |
| Adams | Mo. | 1,200 | 100,000 | Wheat |
| Adair | Nebr. | 1,200 | 100,000 | Wheat |
| Adams | Okla. | 1,200 | 100,000 | Wheat |
| Adair | W. Va. | 1,200 | 100,000 | Wheat |
| Adams | Wyo. | 1,200 | 100,000 | Wheat |
| Adair | Mont. | 1,200 | 100,000 | Wheat |
| Adams | Idaho | 1,200 | 100,000 | Wheat |
| Adair | Utah | 1,200 | 100,000 | Wheat |
| Adams | Nev. | 1,200 | 100,000 | Wheat |
| Adair | Ariz. | 1,200 | 100,000 | Wheat |
| Adams | N.M. | 1,200 | 100,000 | Wheat |
| Adair | Calif. | 1,200 | 100,000 | Wheat |
| Adams | Ore. | 1,200 | 100,000 | Wheat |
| Adair | Wash. | 1,200 | 100,000 | Wheat |
| Adams | Ala. | 1,200 | 100,000 | Wheat |
| Adair | Miss. | 1,200 | 100,000 | Wheat |
| Adams | Ark. | 1,200 | 100,000 | Wheat |
| Adair | La. | 1,200 | 100,000 | Wheat |
| Adams | Tex. | 1,200 | 100,000 | Wheat |
| Adair | N.M. | 1,200 | 100,000 | Wheat |
| Adams | Calif. | 1,200 | 100,000 | Wheat |
| Adair | Ore. | 1,200 | 100,000 | Wheat |
| Adams | Wash. | 1,200 | 100,000 | Wheat |
| Adair | Ala. | 1,200 | 100,000 | Wheat |
| Adams | Miss. | 1,200 | 100,000 | Wheat |
| Adair | Ark. | 1,200 | 100,000 | Wheat |
| Adams | La. | 1,200 | 100,000 | Wheat |
| Adair | Tex. | 1,200 | 100,000 | Wheat |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 3 2 8 1 1
REG. NO. | | | |
|---|--|---|--|---|--|---|---|
| 1. FOR
STATE REGISTRAR | | | | 1. DECEASED NAME FIRST MIDDLE LAST
SADIE (NMN) WEINBERG | | | |
| 2a. DATE OF DEATH MONTH DAY YEAR
12/02/82 | | | | 2b. HOUR
5 A.M. | | | |
| 3. SEX
Female | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
MAR 17 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Hebrew Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Rockville | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Isadore — Herskowitz | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Hannah — Weiss | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6121 Montrose Rd | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Myron Allen | | ADDRESS
5703 Bradley Blv
Bethesda, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTIC SHOCK
5990
DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE URINARY INFECTION
DUE TO, OR AS A CONSEQUENCE OF (c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 Hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
SEVERE SENILE DEMENTIA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
11/30/78 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
6121 MONTROSE RD, ROCKVILLE, MD. | | 21g. DATE SIGNED
12/2/82 | | 21h. SIGNATURE
M.D. — | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/2/82 to 12/02/82 , that (I) (we) last saw the deceased alive on 12/2/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
D. J. PATEL | | 22c. ADDRESS
6121 MONTROSE RD, ROCKVILLE, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-3-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Beth Moses | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Pineblow Suffolk N.Y. | |
| 24. FUNERAL DIRECTOR NAME
W.W. Chambers Co | | | | 25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR SIGNATURE)
DEC 8 1982 | | 25b. ADDRESS
8655 Georgia Silver Spring | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

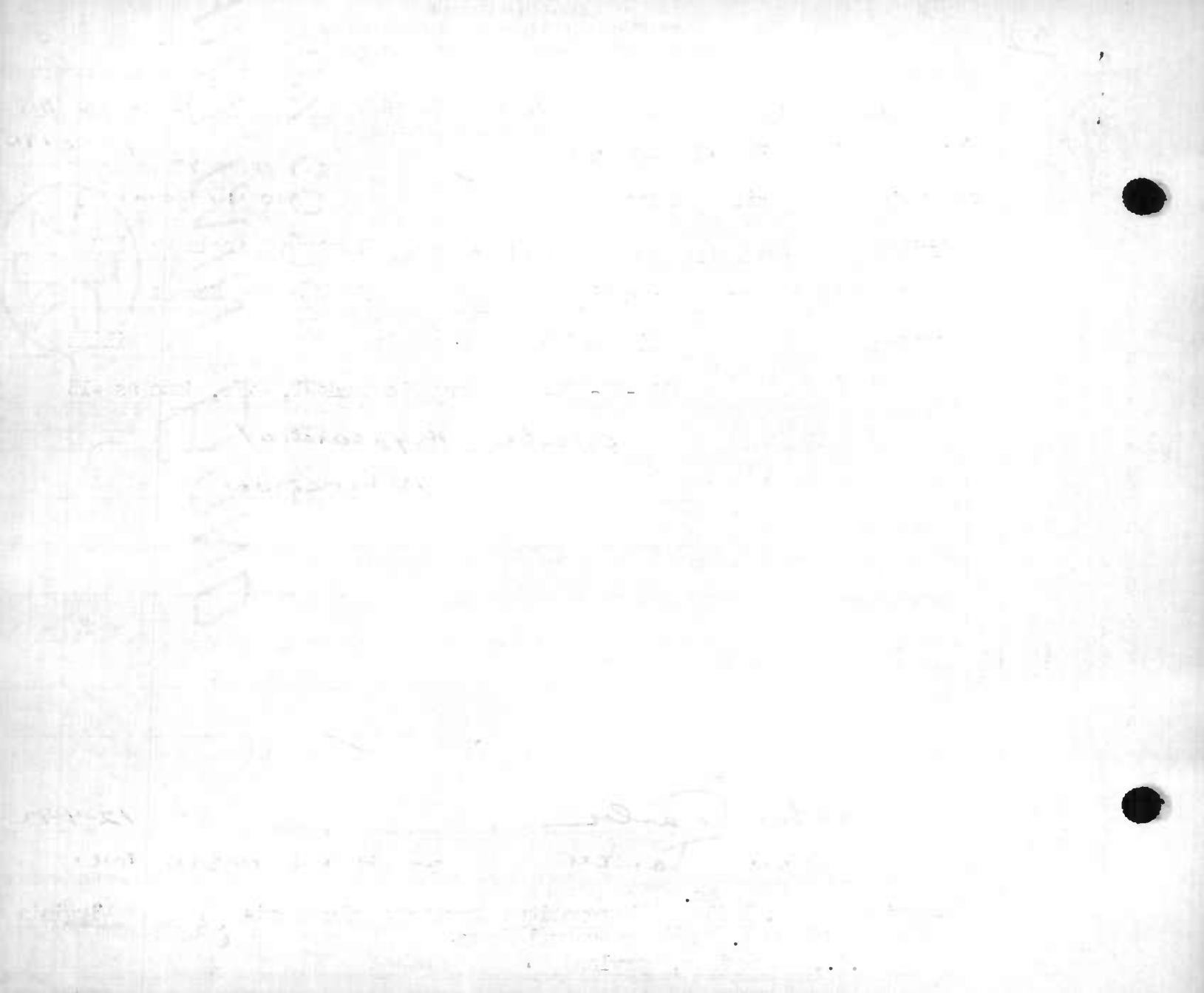
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8 2 3 2 8 1 2
REG. NO. | |
|---|--|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| | | | John G. Werneke | | Dec. 23 1982 | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| Male | | | White | | March 2, 1908 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Maryland | | | U. S. A. | | 74 YRS. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Chevy Chase | | | 5209 Oakland Rd. | | Montgomery Co. MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Retired | | | General Elec. | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. STREET ADDRESS | |
| Maryland | | | Montgomery | | 5209 Oakland Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| John Wernke | | | (Unknown) Lamm | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | 579-38-5884 | | Mary P. Wernke (Wife) 5209 Oakland Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | |
| 4149 IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | Sudden |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | Years |
| (b) Coronary artery disease | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| (c) Atherosclerosis | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| | | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE |
| | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 70 to 19 82, that (I) (we) lost saw the deceased alive on Nov 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED |
| Robert T. Kelley M. D. | | | | | | 23 Dec 82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS |
| Robert T. Kelley M. D. | | | | | | 8218 Wisc. Ave. Bethesda, Md. 20814 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Cremation | | | Dec. 26 1982 | | Suitland Prince Georges Md. | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR |
| Jos. Gawlers Sons 5130 Wisc. Ave. N.W. Wash. D.C. | | | | | | DEC 29 1982 |
| | | | | | | 25b. REGISTRAR'S SIGNATURE |
| | | | | | | John J. Conner |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 3 2 8 1 3 | |
|--|--|------------------|---|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William J. WICHTENDAH | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12 DAY 4 YEAR 1982 | | 2b. HOUR 1915 | | 2c. DATE PRONOUNCED DEAD 12 4 19 82 | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH
MONTH 8 DAY 18 YEAR 30 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | 7. IF UNDER 1 YR. MONTHS 0 DAYS 0 | | 7c. IF UNDER 24 HRS. HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | 7b. CITIZEN OF WHAT COUNTRY? United States | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH Rockville | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) Electrical Engineer | | | 12b. KIND OF BUSINESS OR INDUSTRY IBM | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 518 Mannakee Street | | |
| 14. FATHER'S NAME
FIRST William MIDDLE J. LAST Wichtendahl | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Gertrude MIDDLE Kilian LAST Kilian | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 133-22-1524 | | | | 17. INFORMANT ADDRESS Mary Wichtendahl, Wife, Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) IN function
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John Tauber | | | | TITLE (SPECIFY) M.D. | | | | MEDICAL EXAMINER DATE SIGNED 12-4-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John Tauber | | | | ADDRESS 8218 WISCONSIN AVE. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE Dec. 9, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | | 23d. LOCATION
CITY OR TOWN Alexandria COUNTY Stafford STATE Virginia | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey | | | | | | ADDRESS P.A., Rockville, Maryland | | | 25a. DATE REC'D. BY REGISTRAR DEC 6 - 1982 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 3 2 8 1 4 | | |
|--|--|-------------------------|--|--|--|--|--|--|--|--|-----|--|
| 1. FOR STATE REGISTRAR 1-26-83 cn | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Bessie L. Williams | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR
12 11 19 82 | | 2b. HOUR
10:00 P M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
July 11, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN
85 YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
12 11 19 82 | | 7d. HOUR
10:00 P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | | MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery County General Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
7810 Damascus Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles Ward | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Hattie Duvall | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
220-28-6110 | | | 17. INFORMANT ADDRESS
Ruby W. Hyatt, 26113 Woodfield Rd. Damascus, Md. 20872 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Head Injury Primary pontine hemorrhage due
8809
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) Hypertensive atherosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
7:00 P.M. 12 11 1982 | | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR
7:00 P.M. 12 11 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
fell down stairs | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK
Home | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
2611 3 Woodfield Rd. Damascus, Montg Co., Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED
12/13/82 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Dec. 15, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Damascus, Montgomery, Md. | | | | |
| 24. FUNERAL DIRECTOR NAME
Olgin L. Molesworth, P.A., | | | | | | ADDRESS
Damascus, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Canine</i> | | |

1997

INTRODUCTION

from 1990 to 1998

117

(202)

120

0022-0715/96/0000-0000\$05.00/0

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

011-10-258

500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 3 2 8 1 5
REG. NO. | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Helon Katherine Williams | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-23-82 | | | | 2b. HOUR 5:50 P.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3-19-01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Silver Manor Health Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY At Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE MD | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Cherry Chase | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 7206 Pomander Lane | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Paul -- Hiser | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kunikunda -- Wunderlich | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 579286065A | | 17. INFORMANT ADDRESS Carroll Williams, Same address as # 13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) Cordic arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Valvular dysfunction | | | | | | | | | | 2 years. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease | | | | | | | | | | 10 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19, 1982 to Dec 23, 1982 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on Dec 9, 1982 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Michael R. Dobridge MD | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED Dec 24 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael R. Dobridge MD | | | | 22e. ADDRESS 13975 Connecticut Ave Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. | | | | 24b. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016 | | | | 25. FILED TO REGISTRAR DEC 28 1982 REGISTRAR SIGNATURE John J. Smith | | | |

BP

Items #15a-22a Film G577 3/3/83 r STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4 2 3 2 8 1 6

| | | | | | | |
|--|-------------------------|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARY Gail Cronan Williams | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 12 5 19 82 | | 2b. HOUR
M | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 30, 1937 45 YRS. | 6. AGE (IN YEARS)
LAST BIRTHDAY
45 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 6 19 82 | 2d. HOUR
1:50 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Conn. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10006 Stedwick Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Legal Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Law Practice |
| 13a. STATE
Md. 20852 | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
6906 Stonewood Ct. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Carey F. Cronan | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Reilly | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | |
| 16b. SOCIAL SECURITY NO.
577-52-7370 | | 17. INFORMANT ADDRESS
Ralph I. Williams Same as Item # 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
9505 IMMEDIATE CAUSE (a) Multiple drug intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 12/5/1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
self ingested | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
10006 Stedwick Rd. Gaithersburg Montg. Md. | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | |
| ACTUAL SIGNATURE
H R Guard | | TITLE (SPECIFY)
M.D. Assistant | | | DATE SIGNED 12/7/82 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Hormez R. Guard, M.D. | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/9/82 | 23c. NAME OF CEMETERY OR CREMATORY
St. Gabriel's Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Potomac, Md. | |
| 24. FUNERAL DIRECTOR NAME
Joseph Gawler's Sons, Inc. | | | | 25a. DATE REC'D BY REGISTRAR
DEC 13 1982 | | 25b. REGISTRAR'S SIGNATURE
John J. C... |
| 5130 Wisc. Ave. N.W. Wash., D.C. 20016 | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

WASHINGTON FIELD OFFICE - CIVIL RIGHTS DIVISION

MARY

100-100000

100-100000

100-100000

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100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Item 13b per phone 12/30/82 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 8 1 7

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Robert Francis Williamson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 23, 1982 | | 2b. HOUR
5:45p M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 30, 1940 | | 6. AGE (IN YEARS LAST BIRTHDAY)
42
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Auto Parts Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY
Caroline | 13c. CITY OR TOWN
Federalsburg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elbert F. Williamson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rachel Quillon | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
216-38-8599 | | 17. INFORMANT
ADDRESS
Rachel Williamson, mother, 103 South
Univ. Avenue, Federalsburg, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
3229 IMMEDIATE CAUSE (a) Meningitis
DUE TO, OR AS A CONSEQUENCE OF
(b) Acquired Immunodeficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 months
12 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (X) this hospital attended the deceased from 24 November 82, to 23 December 82, that (X) (we) lost saw the deceased alive on 23 December 82, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
HENRY M ASUK | | DEGREE
MD | | 22c. DATE SIGNED
12/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
The Clinical Center, National
Institutes of Health, Bethesda, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 26 | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Federalsburg Car. Md. |
| 24. FUNERAL DIRECTOR
NAME
Edna Williamson Federalsburg Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1982 | | 25b. REGISTRAR'S SIGNATURE
J. C. ... | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 4. SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 32818 | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Robert C Wilson | | | | | | | | | | 2a. DATE KNOWN OF DEATH 12/29/82 | |
| 3. SEX Male 4. RACE Cauc. 5. DATE OF BIRTH April 23, 1914 6. AGE (IN YEARS) 68 YRS. 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | | | | | | | | | 2b. DATE OF DEATH 12 29 82 2d. HOUR 1134 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? United States 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK) Assistant Vice-President 12b. KIND OF BUSINESS OR INDUSTRY Wash. Gas | |
| 13a. STATE MD 13b. CITY OR TOWN MONTGOMERY 13c. CITY OR TOWN BETHESDA 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS (20817) 7531 CAYUGA Avenue | |
| 14. FATHER'S NAME Charles H. Wilson 15. MOTHER'S MAIDEN NAME Mallisa Lawrence | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. WW II 577-07-7373 17. INFORMANT Anne M. Wilson, same as #13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4100
DUE TO, OR AS A CONSEQUENCE OF
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST:
CORONARY ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE
UNDET | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 10:00 PM 12 29 1982 21b. TIME OF INJURY HOUR: A.M. MONTH DAY YEAR 10:00 PM 12 29 1982 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED AT HOME | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME 21f. LOCATION STREET 7531 CAYUGA DR CITY OR TOWN BETHESDA COUNTY MONT. STATE MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C. Mayle TITLE (SPECIFY) Dep't M.D. MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 12/29/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle ADDRESS 8200 Wisconsin Ave Bethesda MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Dec. 31, 1982 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. 23d. LOCATION CITY OR TOWN Silver Spring COUNTY Maryland STATE MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A. Bethesda, Maryland 20814 25a. DATE REC'D. BY REGISTRAR JAN 5 1983 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | | | | | | | |

MEDICAL CERTIFICATION

Bottom Line

Item 21a&22a Film 576

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 2 3 2 8 1 9

FOR
1. STATE 2-10-83 cn
REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|----------------------|--|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Eva C Willt | | | 2a. DATE OF DEATH
MONTH DAY YEAR
11-02-82 | | 2b. HOUR
846 P.M. | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 18, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9b. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 11. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
-- | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
PG | | 13c. CITY OR TOWN
Upper Marlboro | | 13d. INSIDE CITY LIMITS?
<input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8827 East Grove Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Peter S. Miller | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hester Price | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No -- | | | | 16b. SOCIAL SECURITY NO.
219-03-9300 | | 17. INFORMANT
Ruth W. Hardin | |
| 16c. ADDRESS
Same as #13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
5140 IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>pulmonary edema</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hip fracture</u> | | | | | | | | | | | |
| 9a. DATE OF OPERATION
10/29/82 | | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED
Hip fx | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 12/20 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
fell at nursing home | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
A. Wilson HCC | | 21f. LOCATION
STREET
Guthrie | | CITY OR TOWN
Guthrie | | COUNTY
md | | STATE | |
| 22a. I certify that (1) <u>the</u> hospital attended the deceased from <u>11/2</u> , 19 <u>82</u> , to <u>11/2</u> , 19 <u>82</u> , that (1) <u>was</u> lost
saw the deceased alive on <u>11/2</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated
above, (1) <u>viewed</u> the body after death. <u>Natural</u> | | | | | | | | | | | |
| 22b. SIGNATURE
<u>G. Keger</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
11/2/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Keger | | 22e. ADDRESS
17105 Darnestown Rd. Fort Belvoir | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Nov. 5, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Resurrection Cem | | 23d. LOCATION
CITY OR TOWN
Clinton | | COUNTY
PG | | STATE
Md | |
| 24. FUNERAL DIRECTOR
Robert E. Wilhelm Funeral Home
Suitland, Md. | | 25a. DATE REC'D. BY REGISTRAR
NOV 9 1982 | | | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Smith</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 2 3 2 8 2 0 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) WINIFRED Virginia YATES | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DEC 26 1982 | | 2b. HOUR
11:18 PM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 10 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., DC | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. G.E. Supply | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md. Pr. Geo. Greenbelt | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7503-Mandan Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John F. Stansbury | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eva Kaus | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
577-01-3984 | | 17. INFORMANT ADDRESS
James F. Yates (same as above) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) ACUTE MYOCARDIAL INFARCTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) ATHEROSCLEROTIC HEART DISEASE
1 DAY
12 YEARS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:6 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC 25 1982 to DEC 26 1982 , that (I) (we) last saw the deceased alive on DEC 26 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert L. Kricmar | | | | DEGREE
MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Dec 26 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT L. KRICHMAR MD | | | | 22e. ADDRESS
7733 ALASKA AVENUE NW
WASHINGTON DC 20012 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Nalley's F.H. Inc. | | | | ADDRESS
Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | |

www.colton.it

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called to examine the body.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 3 2 8 2 1 | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CATHERINE V. YOUNG | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 12/16/82 | | | |
| 3. SEX
FEMALE | | | | 2b. HOUR
12²⁹ PM | | | |
| 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR JUNE 8, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2244 COUNTRYSIDE DRIVE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE VIRGINIA 13b. COUNTY GREENVILLE 13c. CITY OR TOWN SKIPPERS | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST AUGUSTUS VINCENT | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST ALICE BROWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
230-66-8235 | | 17. INFORMANT
ADDRESS GOLDEN H. MAYBERRY SAME AS 13 DAUGHTER | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
1.539 IMMEDIATE CAUSE (a) TERMINAL METASTATIC CANCER RT. COLON | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 YEAR |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 82 , to Dec. 16 , 19 82 , that (I) (we) last
saw the deceased alive on Nov. 30 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>William L Amoroso Jr</i> | | | | DEGREE
M.D. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William L Amoroso Jr | | | | 22e. ADDRESS
9801 Georgia Ave Silver Spring Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
Dec. 19, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
YOUNG FAMILY CEMETERY | | 23d. LOCATION
SKIPPERS GREENSVILLE STATE VA | |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS
NAME
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Carter</i> | | | |

THE UNIVERSITY OF CHICAGO
LIBRARY

12/18/82



12/18/82



12/18/82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|--|--|---|--|--|--|----------------------|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Herman Zacharias | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 24 82 | | 2b. HOUR
5:55 P M | |
| 3 SEX
M | | 4 RACE
W | | 5 DATE OF BIRTH
MONTH DAY YEAR
7 2 98 | | 6 AGE (IN YEARS LAST BIRTHDAY)
84 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
German | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Sil. Spr. Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Colonial Villa 12325 N. Harp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cabinet Maker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Brookville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Brookville, Md. 20833
3301 Damascus Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herman Zacharias | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IDA Franke | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
NA | | 17. INTERMEDIATE ADDRESS
3301 Damascus Rd., Brookville, Md.
Mr. Fred W. Zacharias 20833 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4292 Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) S/C R Hemiplegia
DUE TO, OR AS A CONSEQUENCE OF (c) S/C V
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 hr
Years | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Osteomyelitis of femur | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16/82 to 12/24/82, that (I) (we) lost
saw the deceased alive on 12/16/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
C. H. G. GAN | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/24/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
1811 Poppley Dr., Chevy Chase, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-30-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Truman Schwab | | ADDRESS
3512 Frederick Ave. | | 25a. DATE REC'D. BY REGISTRAR
3/10/83 | | 25b. REGISTRAR'S SIGNATURE
John J. Carls | | | | | |

BP

1944

1944

1944

1944

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IN ADVANCE. IF THE DEATH IS SUSPECTED TO BE SUICIDE, HOMICIDE, OR OTHERWISE UNNATURAL, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. IF THE DEATH IS SUSPECTED TO BE SUICIDE, HOMICIDE, OR OTHERWISE UNNATURAL, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. IF THE DEATH IS SUSPECTED TO BE SUICIDE, HOMICIDE, OR OTHERWISE UNNATURAL, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Voula

C.

Zazanis

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2b. HOUR
ESTIMATED ☐ 12/20 19 82 M

3. SEX

4. RACE

5. DATE OF BIRTH
MONTH DAY YEAR6. AGE (IN YEARS)
LAST BIRTHDAYIF UNDER 1 YR.
MONTHS DAYSIF UNDER 24 HRS.
HOURS MIN

2c. DATE PRONOUNCED DEAD 12/20 19 82 P. M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Wash.D.C.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County MD.

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

10000 Brunswick Avenue, #115

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Riggs Bank Bookkeeper

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. CITY OR TOWN

Montgomery

13c. CITY OR TOWN

Silver Spring

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

10000 Brunswick Avenue, #115

14. FATHER'S NAME

Emanuel

MIDDLE

Zazanis

15. MOTHER'S MAIDEN NAME

Katherine

MIDDLE

Kondoleon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

None

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

579 12 9961

17. INFORMANT

1020 Hollywood Ave. S.S.Md.

Diane M. Argyros (Daughter)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial disease

DUE TO, OR AS A CONSEQUENCE OF

4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.(b) chronic myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

None

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

None

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☐Inquiry ☒

and in my opinion

death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

Deputy MEDICAL EXAMINER

DATE SIGNED 12/20/82

EXAMINER'S NAME
(TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS

1919 Seminary Road
Silver Spring, Montgomery, Md.23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

12/22/82

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery Suitland

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

PG Maryland

24. FUNERAL DIRECTOR

Hines/Rinaldi 11800 N.H.Ave. S.S.Md.

25a. DATE REC'D. BY REGISTRAR

DEC 27 1982

25b. REGISTRAR'S SIGNATURE

John J. Carver

100

344

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) NADINE Joyce Zeigler | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12/22/82 | | 2b. HOUR 104 P.M. | | |
| 1 SEX F | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 17 40 | | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY own home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Virginia COUNTY Loudon CITY OR TOWN Lovettsville | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS Rt. 1 Box 186 A | | 22080 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hartwell William Melvin | | | | 15. MOTHER'S MAIDEN NAME MIDDLE FIRST MIDDLE LAST Louise Alice Clark | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF N/A, GIVE WAR OR DATES) N/A | | 16b. SOCIAL SECURITY NO. 213-38-3014 | | 17. INFORMANT ADDRESS Larry E. Zeigler-husband-(same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1991 IMMEDIATE CAUSE (a) Cardio-Pulm Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Pericardial Effusion
DUE TO, OR AS A CONSEQUENCE OF (c) Adverse SA - widespread metastases
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-3 days
5-6 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 1 , 19 82 , to Dec 22 , 19 82 , that (I) (we) last saw the deceased alive on 12-22 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R-H Sandstrom MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12-22-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R-H Sandstrom MD | | | | 22e. ADDRESS 7701 Carroll Ave Takoma Park, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-27-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Burtionsville Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home | | | | 11800 N.H. Ave., S.S. Md. 20904 | | 25a. DATE REC'D. BY REGISTRAR DEC 27 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conish | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 2 8 2 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Gertrude C Zettler | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-18-82 | | | 2b. HOUR
11:45 P.M. | |
| 3 SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
7 13 05 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Ohio | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY
N.I.H. |

| | | | | | | |
|--|--|---|---|--|---|---------------------------|
| 13a. STATE
Md | | 13b. COUNTY
Mont | 13c. CITY OR TOWN
Silver Spg | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
301 Wayne Pl 20910 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DANIEL O'BRIEN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NORA McNEARY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
215-38-6656 | | 17. INFORMANT
MICHAEL ZETTLER | | ADDRESS
SAME AS 13 SON |

| | | | | | |
|---|--|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) <u>Coronary Heart Failure</u>
(c) <u>Arteriosclerotic Cardiovascular Disease</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr
P.M. | |
|---|--|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 (a) OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18/82 to 12/18/82 that (I) (we) saw the deceased alive on 12/18/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Myron L. Lenkin MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MYRON L. LENKIN | | | | 22e. ADDRESS
2309 SHOREFIELD RD.
WHEATON, MD. | | | |

| | | | | | | | |
|--|--|-----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
SILVER SPRING COUNTY MONT STATE MD | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS
500 UNIV. BLVD., W, SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 27 1982 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |

